HEALTH AND ILLNESS EXPERIENCES OF AFRICAN-CARIBBEAN WOMEN AND MEN: A STUDY IN EAST LONDON.

KIM ANN LAWSON

QUEEN MARY & WESTFIELD COLLEGE

DOCTOR OF PHILOSOPHY

1999

ACKNOWLEDGEMENTS.

This study would not have been possible without the help of various significant people. Many thanks go to my supervisors, Professor Sarah Curtis and Dr. Cathy McIlwaine, who have expertly guided me through the course of this study. Equally, thanks go to other post-graduates at Queen Mary & Westfield College, who have provided stimulating discussions regarding the issues addressed in this research and, when necessary, much needed assurances through periods of doubt. Thanks also go to the sponsors of this project, East London and The City Health Authority, who have not only provided the funds for this project but forums where findings and policy implications could be discussed. Finally, this study would not have been possible without those who participated and opened their lives up to my scrutiny. Many overcame serious difficulties in this process – I hope that they will be satisfied that this has been worth their while.

In memory of Lucil Tate.

ABSTRACT.

This thesis explores how gender can affect experiences of health and illness, with the understanding that gender is constructed differently across the life course, and is mediated by 'race' and class relations in Britain. Research was conducted with a small sample of informants drawn from African-Caribbean community groups in east London, using focus groups and in-depth interviews. Findings are three-fold. First, participation in health research itself was problematic for informants, relating directly to their experiences of personal and institutional racism in Britain. Evidence showed that these experiences encouraged informants to use public accounts of health and illness when more structured research methods were used. In-depth interviews encouraged informants to develop more private accounts of their illness experiences. A second finding was that social relations and low social status were often implicated in private accounts as contributing factors to illness. Women and men felt that racialised experiences, especially in the workplace, were problematic for black people collectively. Older female informants also connected personal health problems to their efforts in fulfilling the more traditional expectations of women in the home, family and workplace. Finally there is evidence that women and men have developed a variety of strategies to mediate the impact that social circumstances may have on their health. Some strategies influenced the way that illness discourses themselves were constructed, whilst others focused on building self-esteem through Caribbean or Black identity, or through developing a sense of 'self.' Besides these findings, the methodology of this study is discussed. This was developed in response to the sensitive nature of the racialised research context. Key concerns have been to develop trust and rapport with informants, and to offer them the opportunity to comment critically on this research project and its findings. It was felt that this approach enhanced the insight into informants' reporting and understandings of health and illness. Conclusions of this research have theoretical, methodological and policy implications. Most topical are implications relevant to east London's Health Action Zone strategy. There are specific recommendations for understanding the mental health needs for African-Caribbean communities, and for developing appropriate ways to involve these communities in this initiative and offering them better access to information.

TABLE OF CONTENTS.

LIST OF TABLES.

1. INTRODUCTION.

In this introductory chapter I want to outline what the main focus of this research project has been, where the study is located within contemporary geography, the reasons why it focuses on African-Caribbean populations in east London, a brief outline of the methodology used, and what the findings and conclusions of the research have been. The aim is to 'set the scene' for the chapters that follow, and introduce key theoretical understandings that have guided the methodology, the analysis and subsequent reflections contained within this thesis.

This research is primarily concerned with the connections between gender social position and experiences of ill health. Evidence suggests that women in Western societies experience poorer health than men, a pattern that has become most clear in exploring gender differences in response to self-reported health measures. Because of this, in this project I explore informants' perceptions of their health status.

In addressing gender issues it has been important to consider gendered power relationships in society and how these might be connected to women's and men's health and illness experiences. In particular, the different gender roles of women and men and 'masculine' and 'feminine' discourses that influence women's and men's lives. Exploring the relationship between social position and health and illness further, I have explored these experiences within a minority ethnic group. The racialised position of the African-Caribbean group in Britain signifies different layers of power relationships. The 'race' position that this group is allocated precipitates racialised status and, often, accompanying socio-economic disadvantage as a result of this. In practice the different layers of power relationships are experienced simultaneously. As a result, although the focus of this research is on gender, the ways that gender is mediated by other aspects of social position is explicitly addressed. My concern with issues of power is also reflected in my approach to methodology where I have discussed the implications of social position for conducting research. In the concluding chapter I also address how far methodology might bring about forms of empowerment for those participating in the project.

Considering the exploratory nature of this work, it was decided that a relatively small sample would be used in this study to facilitate a deeper insight into the processes that shape an individual's experience of health and illness. It was also felt that, because of

the limited size and resources of the project, aiming to deepen the understanding of such processes would mean that the experiences of only one minority ethnic group could be explored. The decision to explore health and illness experiences within the African-Caribbean population group was made mainly because my own background involved working in and conducting health research in Jamaica, which provided me with a useful background in some aspects of Caribbean culture.[1] This group was also of interest to study because they represent specific geographies of racialisation and colonialism. In addition, the sponsors of this project, Queen Mary & Westfield College and East London & the City Health Authority (ELCHA), required that the study should explore variations in health status within east London. The boundaries of ELCHA include the boroughs of Hackney and Newham, both of which have significant proportions of African-Caribbeans in their populations (11.2% and 7.2% respectively, compared with Inner London with 7.1%[2] and England and Wales with 1.0%[3]). It was therefore of relevance to the sponsors that this study should focus on the African-Caribbean populations of this area.[4]

1.1. Locating the study within Geography.

The aim of exploring what kinds of social processes may influence the experience of ill health reflects some of the current debates within social and cultural geography. Post-structuralist and feminist critiques have challenged contemporary geographers significantly. In particular, they question the acceptance of 'natural' categorisations and social stratifications, and the reproduction of dominant 'ways of seeing' that represent white, middle-class and masculine perspectives. The dominance of these

---

[1] I acknowledge, however, that Caribbean culture is in no way homogenous across time and space. My own experience of Jamaican culture was in itself fixed and in some ways not comparable to the cultures that are contemporary among African-Caribbean's in Britain today. However, the fact that I had lived in the Caribbean and was knowledgeable about the different ways of life there, was invaluable for gaining respect and an audience with informants.

[2] Source: Bardsley, M. & Hamm, J. (1995) *The Health of Londoners Project: Key Facts and Figures*, London: Public Health Directorate, East London & the City Health Authority. Figures were taken from OPCS 1991 Census (1993) County reports Inner London and Outer London. London: HMSO.

[3] Source for England & Wales figure: East London & the City Health Authority (1994) *Statistical Supplement to Health in the East End 1994/5: Annual Public Health Report.* London: Public Health Directorate, East London & the City Health Authority.

[4] See chapter 2 for an overview of health data relating to African-Caribbeans in Hackney and Newham.

perspectives to the exclusion of others acts to reinforce processes of marginalisation. The effect of this challenge to geographers has been, for example, that social geographers have begun to explore how social stratification and social categories are constructed and supported through ideological and material processes, producing inequalities in society. At the same time, cultural geographers have begun to widen their concept of 'culture' to suggest cultural systems are fluid and changeable, and occur at different scales, reflecting their responsiveness to social and material conditions. 'Culture' is also thought to provide a means to resist marginalised social categorisations (Smith, 1991). These developments in geography have been taken up within the Geography of Health field too, providing theoretical grounding for examining health care systems in Britain. Attention has been given to the dominance of bio-medical knowledge about health and illness, suggesting that such knowledge owes its authorial position in Western society to its ownership by powerful (white, male, middle-class) groups. This ownership has implications for marginalised groups: other health belief systems become marginalised, reflecting larger scale processes of marginalisation. In addition, social power relationships, particularly those constructed according to gender and 'race,' are thought to be reproduced in the interactions between marginalised groups and health-care professionals. This may contribute to the production of health inequalities in access to care. Researchers have been concerned to examine, both quantitatively and qualitatively, the links between health status and social and material processes, whilst phenomenologists have explored the ways that individual's illness beliefs and reporting behaviour is constructed within specific socio-cultural contexts. The influence of post-structuralism and feminism then, has moved geographers, including health geographers, closer to an understanding of the interplay between structure and agency. So that where structural position can influence life experiences, culture may provide individuals with the agency to mediate these experiences.

This project responds to the challenges of feminism and post-structuralism too by aiming to examine how aspects of social position, particularly gender, might influence experiences of health and illness, and how individuals' agency might mediate these. This research considers that a researcher's social position influences the process of research itself, producing findings and subsequent narratives that may represent those

that have been researched in oppressive and repressive ways. Therefore a methodology has been developed that goes some way towards addressing this problem.

1.2. A word about the use of 'race' categories.

One way that representations of marginalised groups can be tackled is through paying attention to the use of terms that may reinforce oppressive understandings of a racialised minority group. Choosing which categories and terms to use in reference to the African-Caribbean group is problematic, and it is useful to briefly discuss these difficulties. 'Race' categories are contentious, particularly as they are widely regarded in the literature as socio-political constructions, legitimated by racialised ideologies and mechanisms of inclusion and exclusion (see for example Anthias & Yuval-Davis (1992), Blaut (1992), Miles (1989) and Solomos & Back (1996)). These categories represent constructions of racial collectivity, which may rest on notions of cultural homogeneity or common hereditary traits, and have been mobilised to exclude the 'other' in various social and historical contexts (Anthias & Yuval-Davis, 1992) through the practice of racism and racialisation. It is therefore legitimate to question the use of 'race' categories as a valid means of differentiating population groups. However, the alternative practice of categorisation along boundaries of ethnicity and culture is also problematic, not least because the definition of each varies amongst those that use these terms.[5] In general, these categories are presented as 'neutral' and as a representation of a 'multi-ethnic' society, when in fact they more often act as a euphemism for categorising black people (Sheldon & Parker: 1992a and Blaut, 1992), thus *masking* the process of racialisation. These categories also assume that ethnicities and cultures are rigid and homogenous, rather than fluid, therefore masking heterogeneity (Anthias & Yuval-Davis, 1992). The choice of how to represent the 'African-Caribbean' group has therefore been difficult. In the context of this study though, two things have been necessary. First, to explore as explicitly as possible the experience of racism and racialised social relations, and the effects that these might have on health and illness; and second, to use informants' own understandings of their location within, and experience of, race relations. To achieve these aims I have chosen to use race categories, the term 'minority ethnic group' and the national-ethnic category 'African-Caribbean' because of their closer representation of informants' racialised experiences. Referring to race categories, such as 'black' and 'white,'

[5] See chapter 2 for a discussion of these terms as they are used in research relating to health and illness.

highlights the political processes that inform participants' racialised social positions, whilst 'minority ethnic group' refers specifically to the minority status conferred to groups distinguished by the 'otherness' of the race and ethnic categories they are perceived to belong to. The category 'African-Caribbean' seems to best represent informants' identification with Caribbean island cultures and their invocation of black African[6] identity as a means of challenging and resisting the marginalised positions of power with which they are faced.

1.3. A moral dilemma: methodological choices.

Beyond the choice of terms, there still remains a moral dilemma regarding the use of categories of stratification as a framework for analysis. The contemporary projects of social and cultural geography, outlined in section 1.1, are useful in explaining processes of both structure and agency (where culture is used as a form of resistance), but together these two approaches can create problems (Smith, 1991; Jackson, 1993). It is my view that to critically examine the ways that certain population groups become structurally marginalised, and how this process is supported by embedded practises of discrimination, is a very legitimate concern. It appears logical to continue the use of social categories as a framework to explore these practices. However, as Smith argues, the continued use of these categories does reinforce the very stratification that allows inequalities to develop and exist. But as Smith (1991) and Jackson (1993) also argue, it is questionable how far these categories can be renounced when those within marginalised positions are using the same categories as a means of resistance to their circumstances, as material from this study will suggest. A more crucial point is that to renounce these positions from the centre (academia might be regarded as a representation of white, middle-class, masculine power), Jackson argues, only reinforces the subordinate position of those who are at the margins of society.

Therefore, finding ways to address this moral dilemma has been at the centre of my approach to conducting, analysing and writing this research. I agree with Smith's hesitancy to use social categories that may act to reinforce hierarchies of position, but the fact that people still experience these positions daily, and the fact that acts of discrimination (whether on the basis of race, gender, age, class or (dis)ability), and

[6] This does not refer to a notion of contemporary African identity (in itself impossible to define) but the notion of a black collectivity that is historically rooted in Africa, and pre-dates the removal of Africans to the Caribbean as slaves by white European colonialists.

resistance to these acts, are practised through these social categories, means that there is validity in continuing to use these categories in an exploratory research context. Therefore I have used these categories as a framework for analysis, but am conscious of the problems involved in this. As a result I have tried to minimise the reinforcement of these categories in other ways. I have tried to address power relationships between researcher and researched. By taking a more reflexive approach to my own position within the research context I have been able to move towards the development of less exploitative research relationships. This has been particularly important in this research because of my own white 'race' position which may reproduce racialised power relationships. The methodology that was developed, therefore, aimed to create and sustain workable relationships with informants. Much of this relied on developing informal relationships with participants before interviews were conducted, and sustaining these relationships after the interviews had taken place. I have also tried to minimise the reinforcement of social categories by using a methodological approach that allowed informants to discuss understandings about their experiences of ill health in their own way. This was done mainly through unstructured group and individual in-depth interviews. These strategies do not entirely resolve the 'moral dilemma', but at least make the existence of social positioning more explicit, move towards ethical research practices and allow informants to represent their own experiences.

1.4. Structuring the research: a guide to the reading of this thesis.

Chapters 2 and 3 discuss the background to the approach and methodology of this project in more detail, with references to related literature. Chapters 4, 5, and 6 discuss the findings of the research in detail.

Chapter 4 examines the discourses that informants used in response to different research techniques and establishes that the public and private accounts that Cornwell's (1984) informants used are also evident in the accounts of illness produced by informants in this study. Findings also suggest that the nature of these accounts are influenced by informants' 'race', gender, stage of lifecourse, and socio-economic status. This research has also explored the ways that informants might respond to different research tools. Much of the research conducted within epidemiology, Public

Health and medical sociology relies on structured questionnaire and interview formats with the aim of developing a general view of the experience of illness of large population groups. Although this is appropriate in some instances, such an approach makes assumptions about how people conceptualise ill health, and does not address social power relations that are both reflected in the constructions of such concepts and in the relationship between researcher and researched itself. Built into this project is an examination of the different health discourses that research tools might encourage. This is based largely on informants' responses to, and group discussions of, a structured self-completed health questionnaire.

Chapter 5 explores informants' own perceptions of how their social location[7] might influence their experiences of health and illness. Section 5.2 examines the connections made between gendered social roles and ill health and the intersection of these and other social factors. In particular, the demands of care roles and the possible role salience that this has for some female informants are discussed. Section 5.3 explores how experiences of gender are mediated by 'race' and socio-economic status in the experience of ill health. Interestingly, findings suggest that whereas gender roles were thought to contribute to personal ill health among female informants, the discussion of health and illness experiences that are racialised were discussed in terms of the health status of the local black community as a whole, rather than as an influence on personal health.

The connections that informants made between their social location and experience of ill health depended in part on the strategies that were used by an individual to overcome structural and social restraints and the illness experience itself. Chapter 6 explores these strategies, which act to mediate and 'resist' difficult life circumstances that were thought to be produced by social position. This chapter draws on a Foucauldian understanding of the nature of power, and illustrates that the transformation of power relations can occur in many different ways. I outline strategies that create empowerment through active resistance, discourses of identity and belonging and seeking guidance from others. I also outline the resources informants draw on to develop these strategies. Many of these resources are cultural, and reflect the use of representations of the margins.

---

[7] This refers to an individual's specific experience of the intersection of 'race', gender and class relations across the lifecourse.

Perceptions, health and illness accounts and the discourses that influence these are clearly difficult to examine separately, and therefore the presentation of analysis in this research is extremely inter-connected. Although the main aim of the research has been to explore perceptions of the relationship between gender and health and illness experiences, methodological findings are also substantive. Findings relating to the development of health and illness accounts are inter-related with material that examines the power dynamics of research relationships. Therefore, chapters 3 and 4, which explore methodology and and health and illness accounts respectively, should be read together. The accounts explored in chapter 4 provide the ground work for discussions in chapter 5 and 6, reflecting the inter-related nature of all the chapters. However, 5 and 6 together explore the relationship between structure and agency and, therefore, can be read separately from chapters 3 and 4. Lastly, chapter 7 pulls all findings together and makes some recommendations related to recent government policy on strategies to reduce health inequalities.

2. THE RELATIONSHIP BETWEEN SOCIAL POSITION AND ILL HEALTH.

2.1. Introduction.

This chapter discusses research relating to the experience of health and illness for African-Caribbean women and men in Britain. Section 2.2 discusses the difference in understanding 'health' and 'illness' between medical and social constructionist perspectives. Social constructionist literature in particular is explored and it is suggested that reports of ill health can reflect social relationships in society. Tools that have been used to measure health status are also discussed in this section, and the different kinds of health reports that structured and less structured research tools can produce are compared. I have taken a critical approach to the question of how far reports of health status from standardised measures can give a comprehensive understanding of health and illness experiences, concluding that in the case of an exploratory project such as this, it is more relevant to use research methods that enable informants to express in their own words what their health and illness experiences have been.

Section 2.3 reviews literature addressing the relationship between gender, socio-economic status, 'race' and ill health. I discuss evidence of a gender difference in the experience of ill health, which may be explained by women's and men's different social roles and the meanings that are attached to these. I also outline the discussion that has taken place about socio-economic status as a causal factor of ill health and point to literature suggesting that ethnicity and culture may contribute to health difference. Although there appears to be clear evidence that socio-economic status is intricately linked to ill health, it is also clear that socio-economic status is often experienced differently by women and men, and between minority ethnic groups and the majority white group in Britain, due largely to gender and 'race' social relations in Britain. Traditional measures of socio-economic status do not always reflect these differences, and I have argued for the use of methodology that allows these different experiences to emerge. I also argue that researchers in the gender and health, and the

'race' and health fields have tended to produce understandings about why variations in health occur which reflect social relationships in society, and the often stereo-typed 'knowledge' about women and men, and minority ethnic groups. I have suggested that the limitations of these kinds of knowledges are at least partly due to the dominant use of a biomedical interpretation of the experience of health and illness that defines ill health through the use of 'objective' medicalised criteria. Not only does this approach 'de-politicise' (Ahmad, 1993) the experience of illness, therefore ignoring the role of structural position and social relations in the construction of ill health, it also supports research practices that do not encourage reflection on the ways in which findings can uphold existing social stratification.

Following these sections which are ostensibly about how structural factors can contribute to ill health, section 2.4 examines the role of agency, and how individuals mediate and resist the effects that their social position has on their health. In particular, theories about the use of illness categories as a means to negotiate social circumstances, and the mobilisation of identity and culture as a means to resist social and economic disadvantage are discussed with reference to what Baldwin *et al.* (1999) term processes of 'counter-power.' Evidence also suggests that the means of resistance can be specific to social location, and in particular, gendered and racialised locations. Lastly, as an antidote to this discussion perhaps, the rhetoric of self-governance as a means of controlling health status is problematised. I suggest that the emphasis on the 'self' as 'controller' of health and life circumstances, which is evident in Health Promotion literature, largely ignores the dominance of structural factors in peoples lives, and therefore the difficulties in tackling these. I also argue that supporting such an approach to health and illness merely acts to de-politicise and subvert the role that structural factors have in the onset of ill health. To conclude, section 2.5 outlines the aims of the research in light of the literature reviewed, and the research strategies that have been developed to explore the interests of the study.

2.2. Measuring health and illness.

'Health' and 'illness' can be defined in different ways and the most dominant understanding about illness and disease in Western society is the bio-medical view (Lupton 1994). [1] According to Curtis and Taket (1996), a bio-medical view is based on four assumptions: that disease is "*deviation* from *'normal'* biological functioning;" that each disease or illness event is caused by a "*specific* pathogenic agent;" that each disease will manifest with similar symptoms in each body, across time and space; and that medicine is scientifically neutral and rational" (Curtis & Taket 1996: 27, original emphasis). As a result, bio-medical researchers are most likely to use medical observation and clinical tests to detect the presence of illness and disease.

Implicit in bio-medical discourse is the understanding that disease and illness occur within a biophysical reality that is separate from, and unaffected by, human interpretation (Miles 1991: 64). However, beyond a doctor's diagnosis derived from scientific measures of symptoms, individuals' constructions of illness have been found to be influenced to a greater degree by friends' advice, experiences and personal life circumstances (Hunt, Jordan & Irwin 1989). The same authors argue that constructions of illness are fluid and changing in a process where "prior history and experience are built upon, elaborated, discarded and so on, as this construction is continually exposed to the exigencies of everyday life" (Hunt, Jordan & Irwin 1989: 945). Others have also suggested that the existence of 'illness' depends on the social and lived interpretation of recognised symptoms, and that actions, or 'illness behaviour', including reporting behaviour, are part of social interpretation (Clarke, 1983; Miles, 1991; and Lupton, 1994). This latter, social constructionist, view of 'health' and 'illness' is the view adhered to in this study because it enables 'health' and 'illness' to be understood as they exist in the context of individual's lives, and considers the processes involved in reporting health status. These are clearly important in a study aiming to examine the relationship between social location ad health and illness. Taking a social constructionist view places value on health and illness measures which capture an individual's *own interpretation* of their symptoms

[1] See McDonald (1981) for a discussion of how political powers can support medicine and medical professionals in a way that can exclude other treatment systems.

and health status, and measures which convey the socio-economic context of individual's lives. Therefore, self-reported health indicators and health and illness beliefs are discussed below.

2.2.a Self-reported health and illness indicators and their limitations.

Self-reported health measures allow informants to rate their health status according to their own perceptions, although some of these measures have been criticised for their tendency to record rates of health service use (Blaxter, 1989; MacFarlane, 1990) and health behaviour (Gijsbers van Wijk *et al*, 1991), rather than levels of morbidity within the population. These measures are useful to discuss in the context of this study because of the tendency for question items to focus on less severe, more everyday mental and physical health problems, and significantly it is within these categories of illness that the most consistent gender difference in white populations emerge. They therefore provide some scope to begin answering the question of whether factors beyond the physiological can influence the experience and reporting of ill health. However, self-reported health measures and the illness categories they tend to explore have received little attention regarding their relevance for the African-Caribbean population. A review of self-reported health data for African-Caribbeans by Curtis and Lawson (2000) examines data from the *Black and Minority Ethnic Groups Health and Lifestyle Survey* 1992 (Rudat, 1994), the *Fourth National Survey of Ethnic Minorities* 1993/4 (Nazroo, 1997a & b) and data for Inner London from the sample of anonymized records of the *British Population Census* 1991 on long-term limiting health.[2] For the purposes of this chapter I will highlight the findings regarding gender patterns.

Findings from the *Fourth National Survey of Ethnic Minorities* (Nazroo, 1997a and 1997b) suggest that on most of the measures used, African-Caribbean women reported more mental illness and more general health problems than African-Caribbean men. Findings from the *Black and Minority Ethnic Groups Health and*

[2] Data is taken from the Sample of Anonymized Records (SAR), a 2% sample of individuals taken from the Census. The data referred to here was for individuals selected from the SAR for individuals living in inner London.

Lifestyle Survey (Rudat, 1994) show, on the other hand, that African-Caribbean men aged over 50 years were more likely to report poor health than women of the same age. Data from the population census suggests that long-term limiting illness was reported by African-Caribbean women more than men in the age group 55-64, but that in other age groups reporting by women and men is similar. Therefore patterns across these particular data sources are not consistent, particularly where age is considered, although there does seem to be a general pattern of women reporting more ill health than men. This highlights some of the problems encountered in the use of self-reported health measures. Wording of question items varies across surveys, which may account for some of the inconsistencies noted above. More importantly, the aim of striving to develop smooth consistent patterns is at odds with the fluid and variable nature of interpreting and reporting health status. Standardized questionnaire items may not be understood and responded to in the same way by men and women in different cultural groups. To further understand the complex processes involved in understanding and reporting personal health status, the following section considers research that has explored how individuals may construct their knowledge about health and illness.

2.2.b A view from within: the validity of understanding and recording individuals' own health and illness beliefs.

Attention to alternative understandings of how 'illness' is defined and recognised is represented by a growth of interest in 'lay' perceptions of ill health which explores informants' own constructed knowledge of their health and illness experiences. This approach can incorporate health beliefs that differ from the bio-medical model. Curtis and Taket (1996) discuss the trend to examine 'lay' views of health and illness and make a distinction between early studies and more recent ones. They suggest that earlier studies were often concerned to establish why patterns in service use and compliance with conventional medicine existed, which led to research comparing different population groups, particularly class, gender, age and cultural groups.[3] Curtis & Taket discuss studies on working class women by Blaxter & Patterson (1982), Pill & Stott (1982) and Calnan (1987) which found links between social class and health behaviour, and in particular the more functional definitions of

[3] Some of the 'gender and health' research discussed in section 2.3.a of this chapter was part of this trend.

health and illness used by them, compared with middle-class women. However, despite the focus that these studies gave to health beliefs, Curtis & Taket suggest that this genre of studies is limited by the lack of attention to the 'plasticity' of health and illness concepts, and the fact that both professional and 'lay' views can interact and alter with context. They also point out that these early studies relied mainly on structured and semi-structured methods, not only were these inappropriate for exploring the "potentially complex and dynamic nature of such beliefs" (Curtis & Taket 1996: 35), but the authors suggest that such findings may be an artefact of these methodologies. They consider whether the nature of the questions used, the greater propensity for middle-class informants to be more articulate than working class informants, and the production of 'public' rather than 'private' health accounts (see below) may produce apparent differences in reported health between social groups which are not borne out in other research.

Curtis & Taket discuss research that they believe does address the complex nature of health and illness beliefs. Most relevant to the present research is their discussion of work by Cornwell (1984) and Stainton-Rogers (1991) whose research is based in Britain. Cornwell used methodology that enabled her to explore more fully the health beliefs of her informants. Her analysis pays attention to the context within which the research was conducted, and Cornwell suggests that where she was able to develop trust and rapport with her informants, different, more 'private' accounts emerged. She characterises 'private' accounts as relatively uncensored and unconcerned with personal responsibility. Instead these accounts express understandings and describe health behaviours that are often idiosyncratic, and which may fall outside culturally acceptable ways of talking about health and illness. Cause is not always described in bio-medical terms. Instead, informants are more likely to talk about "material concerns and practical constraints that intrude into matters of health and illness" (Cornwell 1984: 133).[4]

In contrast, she describes 'public' accounts as an expression of what her informants perceived to be an acceptable way to represent their beliefs about health and illness. This involved some censorship by the informant of other, less acceptable, understandings that they might hold. Such discourses may use medicalised

[4] Donovan (1986) finds that African-Caribbean informants in her study based in east London produced functional accounts of health and illness too.

understandings of the body and illness, and often showed that informants were concerned to legitimate the experience of illness - to present it as 'real' - reflecting a concern with moral behaviour (Cornwell, 1984). These accounts were more likely to be constructed when informants were more guarded about who they were discussing their health with and about the nature of the discussion.

By paying attention to the research context Cornwell makes us aware that discourse about health and illness is changeable and that beliefs have different layers that may or may not be part of the construction the researcher captures at any one time. This might be useful to consider when analysing responses to survey data: might this kind of data collection, which does not involve extended personal interaction between the researcher and researched, be more likely to capture public accounts? This is an issue that I have explored in chapter 4, particularly regarding the effects of a racialised research relationship, where the researcher is white and the researched is black.

Work by Stainton-Rogers (1991) further explores the beliefs that informants hold. She is critical of the simplistic models that have been developed previously, which are based on an assumption that concepts of health either view causes as of external or of internal origin (see section 2.4 for further discussion of this). Stainton-Rogers deconstructs this approach and suggests that understandings of cause are much more complex than this and that 'account sympatricity' occurs where "people have access to and utilise a range of alternative accounts to make sense of health and illness" (Stainton-Rogers 1991: 226). People, then, use health accounts like a library: they can choose the most appropriate account according to the context and question, without losing sight of other accounts. Stainton-Rogers suggests that accounts are selected for many reasons, and particularly as a means to answer questions such as 'why me?' and 'why now?' as well as providing answers to 'what do I do now?' Some of these answers, she argues, reflect understandings of self, cultural ideology and worldviews. Stainton-Rogers categorises eight different accounts from her extensive study, the descriptions of which I have summarised in table 2.1 below. Although it is not the aim of this project to identify different kinds of accounts, these categories are useful as some are used differentially by male and female informants in this study, and across the life course.

Table 2.1. Summary of Stainton-Rogers' accounts of health and illness.

Accounts	*Brief description of accounts*
Body as machine	• Operates in modernist worldview of science • Illness is naturally occurring and 'real' • Biomedicine is the only effective treatment of serious illness
Body under siege	• Individual under threat/attack from germs, disease, interpersonal conflicts and 'stress' of modern life • Factors affect individual through the agency of the 'mind'
Inequality of access	• Endorses the benefits of bio-medicine • Concerned about unfair allocation of the benefits and lack of availability to the most needy
Cultural critique	• Based on 'dominance' sociological worldview of exploitation and oppression • Post-modern understanding that knowledge is socially constructed and mediated by ideology
Health promotion	• Accepts collective and personal responsibility for ill health • Stresses wisdom of healthy lifestyle for good health and illness prevention
Robust individualism	• Concerned with the right of individual to satisfying life and freedom to choose how to live
God's power	• Health is product of 'right' living, spiritual well-being and God's care • Recovery is gained through regaining spiritual wholeness through spiritual power or deity power
Will power	• Individual is in control • Stresses moral responsibility of individual to use 'will' for good health

Source: Stainton-Rogers, W. (1991) Explaining health and illness: an exploration of diversity. London: Harvester Wheatsheaf.

Stainton-Rogers (1991) work provides a framework with which to understand and analyse how informants conceptualise their health and illness experiences, and her work is complementary to that of Cornwell. However, samples in both studies were predominantly white. Some evidence does exist about the concepts held by African-

Caribbeans. Work by Donovan (1986) on Asian and African-Caribbean informants in east London, for example, suggests that the kinds of health concepts used by informants and the way that they are produced supports the findings of both Cornwell and Stainton-Rogers. Donovan found that there is a range of causal factors that informants describe, including germs and viruses, God's will and interpersonal conflicts. Donovan also notes that "some of the informants appear to have a clearly defined idea about health and illness. Such definitions are, however, more flexible than first appears, depending particularly on the context of any episode of ill health and on the individual's previous experience" (Donovan 1986: 113).

2.3 Understanding the relationship between ill health and gender, socio-economic status and 'race.'

The discussion in the above section illustrated that one way of understanding the experience of health and illness is through an exploration of how health and illness is conceptualised. This section will outline how experiences of health and illness can be further understood by examining the effects that social and material circumstances have on health. A large part of the discussion that has taken place regarding variations in health status has focused on aspects of socio-economic status, particularly social class (Curtis & Taket, 1996). However, as Curtis & Taket (1996) suggest, the indicators used to measure aspects of socio-economic status, such as income, housing, occupational status and access to health services are fairly crude and cannot explain health variations completely, nor address the complex nature of living conditions. In particular the measurement of socio-economic status may not reflect the differentiated experience that women and men, minority ethnic and white population groups have of socio-economic status and class. Nor does it reflect the different experiences of health among women and men *within* minority ethnic groups. The following section gives a brief review of the literature that examines the three variables: gender and health, socio-economic status and health, and 'race' and health. I will argue at the end of this section that a consideration of the intersecting nature of these variables will be essential to this study.

2.3.a Gender and ill health.

One approach to understand the relationship between gender and the experience of ill health has been to look at concepts of the body and how they relate to meanings of health and illness and how they are reported. Findings from the two studies outlined below point to the importance of considering the influence of aspects of social position in the construction of health beliefs, which subsequently influence the perception and reporting of health status. Saltonstall (1993) explores health concepts in a small sample of white, middle-aged and middle-class women and men using unstructured interviews. He found that women and men talked similarly about abstract understandings of health. Health was viewed as a state of being related to capacity, performance and function, reflecting the private accounts in Cornwell's study, discussed in section 2.2. He also found that informants perceived the body and self to be interrelated: "respondents' characterisations of the reflexive, contingent and unique nature of the experience of self and body in health dramatically demonstrates the integral nature of embodiment and self-hood. The experience of self as body and body as self constitutes the human experience, and as such, is saturated with notions of moral action and responsibility" (Saltonstall 1993: 9). However, he found that women and men described the interaction between body and self differently. Men understood healthiness to be keeping the body under control, suggesting a sense of ownership over the body, whilst women referred to their body's own momentum. Saltonstall suggests that this reflects gendered understandings of the body and, particularly, the tendency to view women's bodies as passive and men's as active. He argues that this has an effect on health behaviour too. Male informants in his study were more likely to refer to their body as a means to function through the day, and to refer to 'sport' and 'eating well' as a means of maintenance and function. Female informants were more likely to refer to the body as object, emphasising appearance of skin tone and having an agile or thin body, and referred to 'exercise' and 'diet' as a means of maintaining these aspects.

Saltonstall found then, that socially defined ideas of the gendered body are expressed in concepts of health and health practices among a white middle-class population group. Watson (1993) also explores the relationship between body and self, this time among working class, middle-aged male informants in Scotland, using in-depth interviews. His findings contradict those of Saltonstall. Instead of men perceiving

control over their bodies, he finds that there was often a dislocation between self and body among his informants, who perceived their body to have "an existence and subjectivity of it's own" (Watson 1993: 251). This was often expressed through mechanical metaphor, where informants suggested that the body would maintain itself and send out 'warning signals' when "inappropriate or unrealistic body practices" were undertaken (Watson 1993: 249). Watson suggests that this explanation was often used as a rationalisation of 'unhealthy' behaviours that informants were involved in, such as smoking. Watson also suggests that life transitions, such as marriage, work and fatherhood, alongside this notion of body self-maintenance seemed to encourage a fragmentation in the body-self relationship, so that men at these transition points were less likely to become involved in health maintenance practices for the body as prescribed by health promotion. He contrasts this with women's experiences of transitions which, he argues, can act to encourage health practices for the body rather than for self-image. In fact, Watson suggests that men's self-image is controlled by them in such a way as to produce a 'pseudo-body image' based on the memory of a younger 'naturally healthy' body. This "personal fable [acts to] sustain the individual's identity as a normal healthy guy" (Watson 1993: 251).

The differing nature of the findings illustrate the difficulty in generalising about gendered health and illness beliefs, and it is likely that other aspects of social position, such as class status and stage of life-course may also influence health and illness beliefs. Minority ethnic status may influence constructs of health and illness too, although very little research has explored the constructions of health and illness within African-Caribbean populations in Britain, besides Donovan's (1986) work. Clearly, research on how intersecting aspects of social position would help develop an understanding of the construction of health and illness accounts further.

As is suggested in the discussion above, some attention has been given to the health beliefs that informants construct and there is evidence to suggest that health beliefs are influenced by gender ideology to some degree. Other researchers have focused on the risk[5] to health that may be associated with specific gender social relations and social circumstances. In particular, researchers have focused on women's

[5] The term 'risk' in this context is distinct to that used by Health Promotion which specifies lifestyle and lack of self-control as 'risk' factors to health.

experiences of risk with the understanding that these risk factors might contribute to variations in the experience of ill health for women and men. Below I will discuss some of the work that considers aspects of women's social position that may be posing risks. Several hypotheses have been offered to explain the relationship between gender and ill health, the most enduring of which is the suggestion that women's social roles place more stress and burden on women than men's social roles do on their lives. The suggestion of earlier researchers that this is explained by women's socialisation to be more vulnerable to stress, or to be less able to cope with life circumstances than men, has been rejected by feminist arguments (see later in section). Instead, the accumulation of evidence points to the fact that involvement in 'female' roles might be a predisposing factor for stress. Research by Nazroo, Edwards & Brown (1997) provides an example of this. They use a sample of couples living together to explore the different responses by women and men to difficulties arising in the domestic sphere. Findings suggest that onset of depression and expressions of self-blame are more likely in women who are more involved in domestic roles than their partners. The authors suggest that two mechanisms may explain this. First, when men were less involved in a role they were less likely to acknowledge the severity of the crisis since "role differences enable many men to distance themselves from the consequences of domestic crises" (Nazroo, Edwards & Brown 1997: 16). Second, the authors draw on Thoit's work (1991) about 'identity-relevant stressors' to suggest that a perceived 'failure' in salient domestic roles may create low self-esteem and the onset of depression. Where a role is salient to an individual's perception of their identity, undesirable events related to that role are more likely to be viewed as a loss or threat to identity, which has psychological repercussions because it disrupts a valued aspect of self (Simon 1997: 258). Earlier research findings support this argument (for example, Hibbard & Pope 1993; Miles 1988 and 1991; Popay, Bartley & Owen 1993; and Walters 1993). In particular, Miles (1988) discusses at length the relationship between the pressure for women to fulfil social role expectations and their experiences of symptoms of malaise. She also suggests that the low status of housework and waged work that some women and men are engaged in also challenges salient roles for these people, and presents a risk for their psycho-social health.

Simon (1997) reviews work on the meanings of role identity and how this may influence mental health. He identifies an approach that argues individuals'

identification of particular roles as salient is "closely associated with their social positions and which vary by social class, race, and gender" (Simon 1997: 259). The indication is, therefore, that health experience is connected in some ways to challenges to salient roles, and because expectations of social roles may not be uniform for all women and men challenges to certain roles may produce some gender variations in health outcomes. Clarke (1983) and Arber (1989 and 1990a) make the point that structural and cultural factors can alter the experience of gender roles, but there has been little research that examines salient gender roles in minority ethnic groups. The discussion below suggests that the meanings of gender are transformed for black women and men by racialised notions. How this might influence salient roles is not well understood. There is much scope, therefore, for research which attempts to explore understandings of gender and salient roles within minority ethnic groups, and how this might affect the experience of health and illness for people within these population groups.

The findings outlined above illustrate the ways in which researchers have begun to make more explicit the processes involved in experiencing and reporting ill health. The literature about gender differences in morbidity reflects clearly that across disciplines there has been a common acceptance that women and men report morbidity differently. The consensus across many data sources, including both surveys and smaller scale more qualitative studies, is that women are uniformly more likely to report higher rates of illness, assess their health as poorer and consult doctors more frequently than men (see Anson *et al*, 1993; Arber, 1989 and 1990a & 1990b; Celantano, Linet & Stewart, 1990; Macintyre *et al,* 1996; Miles, 1991; Popay, 1992; Popay, Bartley & Owen, 1993; and Verbrugge, 1985 for examples and a discussion of this).

However, the uniformity of reporting patterns amongst women and men has recently been challenged by Macintyre *et al.* (1996) who have shown that such gender patterns in morbidity are not as consistent as has been assumed. According to their study Macintyre *et al.* found that women do not report greater prevalence of morbidity across the life span than men, for all illnesses. Instead, it was found that

only in the categories labelled 'malaise' and 'minor physical' symptoms did women report consistently and significantly greater prevalence of illness than men.[6] [7].

Therefore, although there was a consistent gender difference in the reporting of psycho-social health problems, the lack of consistency in the reporting of other illness categories raises an interesting question about why an acceptance of a uniform pattern of gender differences in reporting has persisted in the past. A contributing factor in the development of a 'women's higher morbidity' paradigm (Macintyre *et al*, 1996) is likely to be the influence of gender stereo-types in the practice and analysis of research in this field. Post-structuralists argue that knowledge is produced through social relations and as such knowledge changes as these alter over time and space. Knowledge is not therefore an independent reality; in fact, post-structuralists would argue that knowledge participates in the construction of reality (Lupton 1994: 11). Therefore knowledge about women and men is intricately linked to gender relations which exist in a society. That certain socially constructed 'knowledge' about women has been used to understand reporting of health and illness is clear in research suggesting that gender differences in self-reported ill health might be attributable to women's greater sensitivity to pain and symptoms of ill-health than men (Miles, 1991 cites: Gove, 1978, 1984; Waldron, 1983; Macintyre, 1986; Whitehead, 1988), thus causing women to report more ill health than men. The notion that women are 'naturally' more sensitive than men may also produce or re-enforce an understanding that women's self-reports of illness are more likely to be influenced by their emotional state than men's reporting behaviour. That such an expectation of 'emotional' reporting among women exists is demonstrated in Goudsmit's study (1994). She found that doctor's emphasise "psychological factors in illness where there is little or no evidence to justify it" (Goudsmit 1994: 7) which can dramatically alter the diagnosis of ailments. For example, Goudsmit found instances where diabetes had been diagnosed as hysterical hyperventilation and cancer diagnosed as Irritable Bowel Syndrome brought on by stress. This process of psychologisation (Goudsmit, 1994) of women's illnesses is

---

[6] These include symptoms that Macintyre *et al* have labelled: 'worrying', 'nerves', 'always tired', 'headaches', 'constipation', 'fainting or dizziness', and to a lesser extent, 'difficulty concentrating', 'sleeping problems' and 'bladder and kidney problems'.
[7] Although Kandrack, Grant and Segall (1991) also reported non-uniform patterns of morbidity between women and men.

corroborated by others (for example, Clarke, 1983; MacIntyre, 1993; and Miles, 1991).[8]

The psychologisation of women's reporting behaviour may contribute to the development of a 'women's higher morbidity' paradigm while, until recently, researchers have remained relatively silent about men's reporting behaviours. The lack of discussion and research into men's self-reports of ill health seems to suggest that men are expected to report more rationally and objectively, and therefore provide the normative experience against which women's reporting is compared. Radical feminists would perhaps go further to suggest that the stereo-typed notions of women and men reflected in some of the literature in this field are upheld and reinforced by the fact that bio-medical knowledge, a traditional bastion of (white) male authority, is influential in the discussion and research of health inequalities.

2.3.b. Socio-economic status and ill health

The Black report (1980) showed clear evidence that inequalities in rates of mortality and morbidity in Britain correlate with socio-economic status. Since the publication of this report much work has been done to develop further an understanding of which aspects of socio-economic status contribute to health and illness status, and the processes by which these aspects affect individuals health. Employment status is one aspect of socio-economic status that has received much attention, and there is strong evidence to suggest that lower status occupations, particularly manual and unskilled jobs (classes IV and V), are associated with poorer health, whilst higher status occupations (classes I, II and III) are associated with relatively better health. For example, evidence from the General Household Survey shows that self-reported limiting long-standing illness is greater among individuals of occupational classes IV and V, and that the same relationship is apparent in the self-reporting of other more common diseases, including psycho-social ill health, in the 1988 Health and Lifestyle Survey (Davey Smith, Bartley & Blane, 1990; Townsend, Davidson & Whitehead, 1992).

---

[8] See MacIntyre (1993) for a discussion of evidence that suggests that women do not have significantly lower thresholds of pain and do not 'over-report' in relation to men.

One outcome of the Black Report has been the development of new indices with which to measure socio-economic status, beyond the occupational class index used in the Black Report (Davey Smith, Bartley & Blane, 1990). New indices include income, wealth, housing tenure and quality, car ownership, employment, education and geographical location (Shouls, Congdon & Curtis, 1996)[9], and there is much evidence to suggest that all of these factors are associated with health status. In general, lower status and greater material deprivation are positively correlated to poor health.

The relationship between socio-economic status and health then, is complex. A variety of factors reflecting life circumstance can indicate whether an individual will experience ill health within their life-time. However, evidence also suggests that the impact socio-economic factors may have on health status is mediated by other variables such as age, gender, 'race' and ethnic group. The importance of age as a variable is noted, for example, by Whitehead (in Townsend, Davidson & Whitehead, 1992) who discusses evidence suggesting that socio-economic status may not be such a clear indicator of ill health for adolescents as for adults. Age as an important variable in the analysis of self-reported ill health is also noted in the discussions of MacIntyre *et al* (1996) and Curtis & Lawson (2000), each of whom found that both women's and men's self-reported health status was variable between age groups

There is evidence to suggest that there are some direct links between health and ethnicity. Research on links between specific diseases and ethnic groups is discussed at length by Smaje (1995), and although it is not the intention to repeat his discussion, I will briefly outline the links between four diseases and illnesses and the African-Caribbean ethnic group that Smaje's pinpoints in his review. Firstly, *Cerebrovascular disease (CVD)* has been positively correlated with the Caribbean born migrant group. Smaje (1995) notes that CVD is prevalent in Jamaica where many Caribbean migrants to this county originated, and that this suggests a pathogenic explanation to account for African-Caribbeans experience of CVD might exist. Other risk factors for CVD are thought to be hypertension (Cruikshank, 1989) and sickle cell disorders, whilst it has also been suggested that low incidence in

[9] Health inequalities have been linked to broader geographical areas. For example, the Black Report (1980) discussed a broad north/south divide in Britain; Watt, Franks and Sheldon (1994) discuss health inequalities between urban and rural areas; and Townsend, Phillimore & Beattie (1988) discuss variations between poor and affluent areas in relation to health status.

coronary heart disease has left more African-Caribbeans 'available' to experience CVD (Cruikshank, 1993). Secondly, *Sickle Cell disorders* have been found predominantly in the African and Caribbean populations in Britain. These disorders are understood to be inherited and related to a genetic trait which helps to protect against malaria. Thus, Sickle Cell disorders are thought to be more prevalent among populations originating from areas where malaria is endemic, such as the African and Caribbean populations. Thirdly, *non-insulin dependent diabetes mellitus*, and the possibility of secondary complications such as end-stage renal disease, are also prevalent among minority ethnic groups, including African-Caribbeans. Smaje (1995) outlines evidence that suggests there are gender differences in the experience of this disease, with greater prevalence of diabetes among African-Caribbean women. Smaje states that cause is likely to be an interaction of genetic, environmental and lifestyle factors, and work by Shaukat & Cruikshank (1993) suggests that early insulin deficiency may be a possible causal factor. Fourthly, research has shown high rates of psychiatric admission among African-Caribbean men for *schizophrenia* (for example, Smaje cites Littlewood, 1992; Harrision, 1993; and McGovern & Cope, 1987), particularly among British born African-Caribbean men (McGovern & Cope 1987). Causal factors for this rate of admission are far from clear cut, particularly as the methodology used in the studies which report this trend are themselves under scrutiny (Smaje, 1995). Those that have accepted these findings of higher admission point to problems in cross-cultural applications of psychiatry and racialised attitudes towards minority ethnic groups both at admission and in the treatment of their condition.

There are then, cases where illness and disease within ethnic groups can be linked to differences in genetic and biological make-up. Other studies have shown that ethnicity is related to health status (for example, Townsend, Davidson and Whitehead, 1992; Cruickshank, J and Beevers, D 1989; and Ahmad 1993) although there is much discussion as to whether this evidence reflects factors specific to aspects of a minority ethnic group's culture and experience in Britain, or socio-economic factors alone. The relationship between socio-economic status and variables such as gender and 'race' is discussed below.

2.3.c Interactions of gender, economic position, 'race' and health status

While as has been shown above there is reason to suppose that gender, socio-economic position and ethnicity might each have independent effects on health, there is also a good deal of evidence that they are interrelated in complex ways. Arber (1989, 1990a) and MacFarlane (1990), amongst others, have examined gender as a mediating variable in measuring the relationship between socio-economic status and self-reported ill health, and note the difficulties that arise when using the same indicators of socio-economic status for both women and men. They have gone some way towards demonstrating that commonly used indices of socio-economic status, which are often primarily developed according to understandings of men's experiences (the uniformity of which can also be scrutinised), may not adequately identify socio-economic status of women. For example, Arber's (1990a) secondary analysis of General Household Survey data highlights that while occupational status is closely linked to material circumstances for married men, this may not be the case for married women whose material circumstances may reflect their husbands' status rather than their own. Therefore occupational status may be a less accurate measure of material circumstances for some (although perhaps not all) married women. Although this might suggest that occupational status is a more relevant measure of material circumstances for single or divorced women, this may be an over-simplification when other factors are considered. For example, similar jobs may not offer the same status (or income) for women and men, and their experiences within the work place may also vary, particularly where women experience sex discrimination.

Attempts have been made to suggest alternative indices that may capture women's circumstances more appropriately. For example, Arber (1989) suggests using the highest income in a household as an indicator of material status, rather than the traditional use of husband's income. Curtis & Taket (1996) cite studies which suggest that other factors are more significantly associated with ill health than occupationally-defined social class, such as working conditions, education level, housing tenure and quality, income and ownership of goods (Curtis & Taket, 1996: 90). The use of these indices of socio-economic status may be more appropriate for women than men.

It is important to develop alternative measures for women's circumstances in order to better understand the relationship between socio-economic status and health. However, as previous sections of this chapter have illustrated, it is equally important to consider the differential access to social power and status experienced by women and men, and the meanings that women and men attach to their social and material circumstances and health status. These factors are complex and variable, made more so by the mediation of these by other aspects of social position such as 'race' and ethnicity.

Measuring 'race' and ethnicity, and the relationship between these variables and socio-economic status, and the consequent effects of these factors on health has also prompted much debate. Although it is plausible to use material disadvantage as an index of socio-economic status in order to assess the relationship between socio-economic status and ill health for minority ethnic groups, Smaje (1995) argues that it is more common for researchers to attempt to *control for socio-economic status* when analysing health data for minority ethnic groups, in effect eliminating this factor as a variable. This tendency can be criticised. First, controlling for socio-economic status assumes that this factor can be measured similarly among groups who do and who do not experience racial discrimination in Britain (see section 2.3.c). Nazroo (1997a) has responded to this criticism by using a composite measure of standard of living, rather than occupational status, as an indicator of socio-economic status in acknowledgement that the experience of occupational status is not always comparable for minority ethnic groups and the white population. Use of this measure also reflects an understanding that various aspects of socio-economic status may contribute to material circumstances and the association between this and ill health.

Second, when controlling for socio-economic status shows a positive association between ill health and an ethnic group, reasons for this interaction have often been left unexplored. As a result, there is an implication that the ethnic group itself is a causal factor in the onset of ill health. Researchers are beginning to examine the processes that link race, social position and ill health. For example, Modood et al. (1997) suggest that racial discrimination may create poorer life chances for minority ethnic groups which impact on health, whilst Lillie-Blanton & Laveist (1996)

suggest that factors such as political empowerment, individual and community control and influence also affect health status (see section 2.3.c.).

The use of socio-economic indicators alone to assess the relationship between social status and ill health within an ethnic minority population group, does not then capture the complexity of the relationship, even where measures of socio-economic status are appropriate to the group's experience of material wealth and status. Evidence does show that socio-economic status is clearly linked to ill health, but that by measuring differences in health in relation to socio-economic status alone the complexity of this relationship, which is mediated by other aspects of social position such as age, gender and 'race,' is not readily captured. In addition, using systematic measures of socio-economic status does not allow the meanings people associate with social and material circumstances to emerge, and it has been shown that these are important to consider in order to understand the experience of health and illness more fully.

In addition to these criticisms it is notable that gender and race variables are rarely considered together.[10] There is, however, evidence of interaction between race and gender differences in health. Using figures from the sample of anonymized records from the 1991 Population Census for inner London populations, Curtis & Lawson (2000) suggest that reporting of limiting long-term illness was higher among African-Caribbean women than among men. Among the white population, for some age groups, the reverse gender pattern of reporting of limiting long-term illness evident. Material from this project offers further insight into the relationship between race, gender, material disadvantage and health status (see chapter 5).

2.3.d The significance of racism for health difference

The previous discussion has shown that it is difficult to examine the relationship between (black) 'race' status and ill health without some reference to material disadvantage. As Anthias & Yuval-Davis (1992) comment, "very few writers on race would dispute the facts of racial disadvantage, particularly in relation to economic disadvantage" (Anthias & Yuval-Davis, 1992: 62). However, although

[10] See Curtis & Lawson (2000) for a discussion of the patchy and inconsistent nature of such data.

'race' and economic factors are connected together by writers, it is difficult to demonstrate that this is specifically the outcome of practices of racial exclusion, particularly when such practices are not always visible as Solomos (1993) argues. He suggests that processes of racial discrimination "are established, routine and subtle; only occasionally will an individual act of racial discrimination become visible within these processes ... [thus] the denial of racial discrimination is common because, quite simply, it can be denied, due to the normality of its invisibility" (Solomos, 1993: 80). In addition, processes of exclusion are not experienced homogeneously by all minority ethnic groups. Instead, these might vary according to historical colonial and immigration 'race' relations, the sectors of the labour force that migrant groups occupy and their geographical location within Britain. For example, there is much evidence to suggest that those who immigrated and those born in Britain have experienced some kind of racism during their lives, although the actual nature of racism may have varied. Constructions of 'race' categories vis-à-vis white British 'race' identity, and the fears and expectations of black minority ethnic groups, have changed over time producing different kinds of racisms. Most African-Caribbeans living in east London arrived between 1945 and 1981, either looking for employment or joining family members that were already settled here. The 'first-wave' migrants arrived at a time when members of the Commonwealth were automatically given the right to British citizenship and therefore their 'race' identity was constructed mainly around colonial ideas of the 'other'. However, Solomos (1993) argues that successive governments since the 1940s have moved to discourage the immigration of *black* people to Britain. This culminated in the 1981 Nationality Act which effectively excluded non-white members of the Commonwealth from British citizenship, thereby legitimising racial discrimination in policy. Alongside these policy developments, Solomos argues that the 'problems' created by black immigrants in Britain received a lot of focus in popular politics and the media, fuelled, he suggests, by fears of the unrest noted in cities in the United States. As a result, this may have encouraged the construction of a more racialised notion of white British collective identity, thus *further excluding* those perceived to threaten the 'racial character' of Britons, as exemplified in Enoch Powell's 'rivers of blood' speech in 1968. This rhetoric of fear shifted focus in the late 1970s and early 1980s from the dangers of immigration to the potential threat of a disaffected black youth within British cities, particularly following the Brixton and Toxteth riots of 1981 (Solomos 1993). The ideological basis for racial discrimination

then, may have shifted from that based on an individual's physical attributes to that based on a more pathological understanding of African-Caribbeans. These changing constructions of the 'other,' vis-à-vis white 'race' and ethnic identity, are likely to have produced different experiences of discrimination over time, as well as a differentiated racialised identity across generations of migrants and African-Caribbeans born in the UK.

There has been work that attempts to explain how outcomes of these processes might relate to health status. Lillie-Blanton & Laveist (1996), for example, suggest that the poorer health of American black populations vis-à-vis white populations can be explained by social conditions that promote disadvantage. Specifically they point to poor employment and education opportunities, poor neighbourhood surroundings and working conditions, poor relations within the work place and community, and poor access to political empowerment, individual and community control and influence (Lillie-Blanton & Laveist, 1996: 85). They argue that when people experience poor social conditions such as these they are exposed to greater injury, ill health and low self-esteem, and they find that minority ethnic groups are more likely to experience these environmental conditions due to limited financial resources and discriminatory practices. Bryan, Dadzie & Scafe (1985) discuss a similar relationship between exclusionary practices and health problems that black women experience in Britain. They discuss direct health hazards in the low status jobs that black women are often limited to, and how limited access to education and jobs, the low bargaining position of being of low economic status, and the 'double burden' of maintaining a home and family as well as a job increases women's levels of stress and anxiety. They also refer to a poverty trap where institutional racism means jobs are hard to find and women often become dependent on the state for housing and income, and report that inadequate and racially biased provision of housing affects mental and physical health.

These relationships often vary with location. Details from the Health of Londoners Project (Bardsley & Hamm, 1995) suggest that the inner city boroughs of London, including Hackney and Newham, are "characterised by high levels of unemployment, overcrowding, lack of material goods and high levels of unskilled persons" (Bardsley & Hamm, 1995: 16). This evidence is supported by Banatvala & Jayaratnam (1996) who argue that levels of unemployment in all east London ethnic

minority groups are high. Relevant to this research, they note particular pockets in Newham where over 40% of African-Caribbean men are unemployed, and that African-Caribbean women are more likely to be unemployed than other women in east London. They also argue that where minority ethnic groups are employed, they are concentrated in low-paid jobs with poor working conditions and unpredictable shift hours. In addition, the authors show that housing disadvantage is experienced disproportionately by minority ethnic groups in east London. With socio-economic conditions such as these it would be plausible to suggest that mental and physical ill health status would be affected. Indeed, Bardsley & Hamm (1995), using 1991 Population Census data, do suggest that the more deprived boroughs in London do have high rates of long-term limiting illness. For example, Curtis and Lawson (2000) show for inner London populations that statistical differences between African Carribean and White women in illness reporting was largely, but not completely, explained by a measure of material conditions.

As with constructed knowledge about gendered experiences of health and illness (see section 2.3.a), constructed knowledge about the health and illness experiences of black and minority ethnic groups in the UK also reflects prejudices social relations within society. Just as researchers have questioned the 'emotional' content of female reporting of ill health, there has been a tendency for researchers to suggest that 'ethnicity' and the cultures of minority ethnic groups is 'problematic' in the experience of illness. There has been strong criticism of this approach. For example, Bhopal (1995) argues that the perceived negative associations between culture and illness are sustained through research that finds associations between disease and ill health and minority ethnic groups but which does not examine reasons for these apparent associations. The implication is then, that 'ethnicity' is the cause of ill health (Bhopal, 1995). Where certain illnesses are found to be prevalent amongst a particular ethnic group, cultural and lifestyle practices of the group are implicated as causal factors in the onset of ill health.

Some researchers have argued that the use of the category 'ethnicity' upholds racialised differences between population groups. Sheldon & Parker (1992a) for example, argue that 'ethnic group' is not used as a 'neutral' identity which celebrates diversity, but has become a euphemism for a racialised view of black people, and that "some people would still assert that there is a more deterministic relationship

between physical and cultural variation" (Sheldon & Parker 1992b: 60). Blaut's work (1992) endorses this argument, and he problematises in particular the term 'culture.' He suggests that because the term 'culture' is mainly associated with 'otherness' (i.e. the term 'culture' is not often applied to European or Western social dynamics), and because 'other' cultures are still represented by black and minority ethnic groups of people, physical and racial distinctions are therefore still used. Blaut suggests that the ideology behind this 'cultural racism' (Blaut, 1992) forms an alternative to biological racism (i.e. racism based on differences in phenotype). He argues that this ideology is based on an understanding that racialised groups "have a capacity equal to that of other so-called races, [but] they have not been able to realise this capacity ... They have not learned how to think rationally, as mental adults. They have not learned to behave in appropriate ways, as social adults. The problem is culture, not biology" (Blaut 1992: 290). The notion of 'culture' in bio-medical and health research has been described as reductionist (Ahmad 1993), where 'culture' is used as a euphemism for 'lifestyle'. This represents culture as a "rigid and constraining force", frozen in time and space, rather than a "nurturing and sustaining" one (Ahmad 1993: 19). A more appropriate understanding of 'culture', and one that is adhered to in this thesis, is that it is comprised of "systems of shared ideas, systems of concepts and rules and meanings that underlie and are expressed in the ways that humans live" (Helman, 1990: 2, citing Keesing, 1981). Helman (1990) suggests that cultures provide a lens through which people perceive and understand the world, but that it is a lens which is continually adapted by people in response to circumstance and the influence of other cultures. Culture is therefore inherently changing and can not be understood as a homogenous entity.

Cultural racism can be identified in the way that culture has been highlighted in the growing body of transcultural medical literature, written by so-called cultural 'experts'. This literature acts as a 'hitch-hikers guide' (Sheldon & Parker 1992a) to cultures and the health problems that each culture is thought to promote. The result has been an alignment of certain illnesses with certain 'ethnic' groups whose 'ethnic' culture and genetic makeup are implicated as problematic, creating an "ideology of victim blaming" (Ahmad 1993: 12). For example, this occurs in discussion of sickle cell anaemia, lupus and schizophrenia in relation to African-Caribbean groups. There is also a tendency for researchers to focus on the more 'exotic' illness experiences of this population group (Ahmad 1993; Stubbs, 1993) rather than their

more everyday health experiences. This both reflects and re-enforces the understanding that ethnic minority populations might experience 'different' health problems to the majority white group and that this 'difference' is somehow related to their culture and their 'race'. As a result more everyday health problems have largely been ignored in research, reflected in the fact that only recently has attention been given to health measures that might capture this experience. The tendency to use white sample groups as control groups in the analysis of minority ethnic groups experiences of illness further implies that the illness experience of minority ethnic groups is 'different' and exotic. This is similar to the way that gender and health researchers have accepted male reporting as normative, and the failure to problematise or even define white 'culture' and lifestyle implies that this is taken as the more normative experience.

2.3.e Towards a contextualised and intersectional approach.

This review of literature suggests that a wider understanding of the experience of both 'race' and gender, that views these experiences as inter-related, is necessary in order to examine more effectively how social identities might influence the experience of health and illness for African-Caribbeans. Understandings of women and men, across ethnic groups, has been challenged by Western radical feminists who argue that patriarchy, which is thought to uphold male power over females (Anthias & Yuval-Davis, 1992), has enabled men to dominate the authorship of knowledge. Therefore, 'knowledge' often reflects a male rather than a female perspective. Radical feminist researchers have often challenged knowledge that has been authored within male dominated disciplines such as medicine, and which rests on essentialist or reductionist understandings of women, in order to produce an understanding of women's experiences that is based on their voices. This challenge is visible in the gender and health field, where feminist researchers have explored women's experiences of ill health in more detail, using methodologies that allow female informants to talk about their experiences in a less constricted way.[11]

Accepting women's reporting as 'real' rather than as an artefact has produced different knowledges about gender differences in health reporting, although a

[11] Survey items and structured interviews often 'direct' responses – see chapter 3 for a fuller discussion of this.

'women's higher morbidity' paradigm remains. Feminists have examined gender social relations as a causal factor of ill health, implicating in particular the gender roles women are expected to undertake and the relative low status of women vis-à-vis men. Although this approach goes a long way to make women's experiences of health and illness more visible, the tendency of feminists to focus solely on white women's experiences reflects the assumption of radical feminist theory that the experience of 'woman' is universal. Anthias & Yuval-Davis (1992) contest this assumption, arguing that it rests on an essentialist and static understanding of the categories 'woman' and 'man', and presumes that women and men continuously oppose one another. They and other black feminist writers also argue that Western feminism is ethnocentric, because of its failure to recognise that the experience of gender for black and ethnic groups differs from the experience of white groups because of colonialism, racism and racialised social relations (Bryan, Dadzie & Scafe, 1985; Anthias & Yuval-Davis, 1992; and Douglas, 1992).

This is illustrated, for example, in the continued understanding in white British society of black family structures as 'dysfunctional.' This reflects the comparison made with family structures that are acceptable in the West (see Phoenix, 1990; Douglas, 1992; and Pulsipher, 1993a for a further discussion of this), which may result in children being removed into care (Bryan, Dadzie & Scafe, 1985). Other writers suggest that gendered understandings of black women and men are influenced by the depiction of black women and men in roles as rapists, prostitutes, pimps, or as sexually promiscuous characters, through the medium of television and film, and within black music itself (Bryan, Dadzie & Scafe, 1985; Cooper, 1993; Ellis, 1986; and hooks, 1991). They argue that as a result black men are more likely to be perceived as physically violent, and that the perception of black women as sexually 'available' may result in sexual violence towards black women being more 'acceptable' than towards white women (Phoenix, 1990). Social construction of gender identity for African-Caribbean women and men may therefore create difficulties that are not experienced by white women and men.

The outcome of this in terms of gender and health research is that few researchers have explored the everyday illness experiences of black and minority ethnic women and men, and those that have done so have tended to be black themselves. Although white feminists have explored the possibility that white women's experience of

illness may alter according to class and socio-economic status (Downey, & Moen 1987; Rosenfield, 1989; Bartley, Popay, & Plewis, 1992; Doyal, 1995), there is little work that explores how the experience of gender itself may be altered by racialised relations, and how this might affect health status.[12] There is strong evidence that racial and ethnic exclusion and sexism in employment exists, particularly for 'first wave' migrants (Anthias & Yuval-Davis, 1992). Not only might this discrimination affect material circumstances and quality of life, but may also create conflict where women and men are not able to fulfil gender roles and expectations that have specific value, a conflict which has previously been shown to be linked with health problems. There is also evidence that racial discrimination in access to employment means that minority ethnic groups are more likely to be exposed to greater health risks within the work place (Bryan, Dadzie & Scafe, 1985). Therefore the experience of 'gender' for African-Caribbean women and men in Britain may be fundamentally different to the experience of white women and men, as racialised understandings of minority groups alter the gender roles, identities and expectations of African-Caribbean females and males. It is the aim of this research then, to explore the meanings that 'gender' and 'race' have in the lives of African-Caribbeans, including meanings understood by African-Caribbean men whose experiences have so far been seldom documented. The changing historical context of 'race' relations in Britain, and the subsequent changes in the relationship between social position and ill health across the life course, indicate a need to include African-Caribbeans of different ages in this study.

2.4. Resistance and processes of counter-power.

In chapter 1 I noted that cultural geographers have become interested in processes of resistance, especially the mobilisation of aspects of cultures as a means to resist social marginalisation. These processes have often been explored through the discussion of power, and this is the approach that I will take in this thesis. Power is extremely difficult to define, but Baldwin *et al.* (1999) offer a succinct discussion of how the concept of power might be best understood. They suggest that the common conception of power having only negative effects (i.e. where power is used, in

[12] See McIlwaine (1995) for a discussion on the dearth of literature that addresses adequately the interlocking nature of gender, race and class.

various ways, to prevent people from doing what they want) is limited, and that Foucault's understanding that power can be productive offers a much wider application to social processes. Understanding that power can be produced *everywhere* (Foucault, cited by Baldwin *et al.*, 1999) enables us to move beyond an exploration of relationships where dominant groups and institutions subject other groups to marginalisation, towards an exploration of 'counter-power' (Baldwin *et al.*, 1999: 95) where marginalised groups resist their position, or at least mediate their experiences of marginalisation. Pile's understanding of resistance is useful to consider as it compliments the idea of counter-power. He argues that "resistance becomes a mode through which the symptoms of different power relations are diagnosed and ways are sought to get round them, or live through them, or to change them" (Pile, 1997: 3). Pile also suggests that resistance is not found at the interface between the oppressor and oppressed, but where resistance actually takes place. This is particularly important to note for research based on verbal interaction as this study shows: resistance may be expressed within the research relationship and through different discourses that are used. These forms of counter-power are more effectively discussed with reference to examples, as in chapter 6 of this thesis. As background to this later chapter, I will use this section to outline research that explores forms of resistance and mediation that are of particular relevance to African-Caribbean women and men. I have also included a critical discussion of Health Promotion discourses of self-governance; first, because some informants use this discourse as a means to change their circumstances and, second, because the use of an over-simplified understanding of power within this discourse has implications which will be discussed in the concluding chapter of this thesis.

2.4.a Illness as a negotiating device.

The term 'negotiating device' makes reference to resistance by means of adopting a particular type of sick role which can alter social circumstances (Doyal 1995). Researchers who have examined the illness category *ataques de nervios* have suggested that symptoms of this illness may be expressed as a means for individuals to alter their circumstances. This category of illness is most commonly found in South American countries and symptoms vary from "shouting uncontrollably, trembling, heart palpitations, a sense of heat in the chest rising into the head, fainting and seizure like episodes" (Guarnaccia, 1993: 158) in Puerto Rico to malaise-like

symptoms in Peru (Doyal, 1995) (see footnote 6 of this chapter for a description of these symptoms). Guarnaccia (1993) argues that those who exhibit symptoms of *ataques de nervios* are those experiencing various forms of social disadvantage. For example, they are usually expressed by women, and are more common among those lacking high school education, those who are unemployed and those experiencing separation or divorce from a spouse. She argues that sufferers are also less satisfied with their social and emotional lives and derive less benefit from their leisure time. Guarnaccia does not explain this relationship between illness and social circumstances in terms of counter-power, but her argument that "what is most salient and meaningful about illness categories [is that they] are not only syndromes of symptoms, but also syndromes of meanings, of life experiences, of response of significant others, and of social circumstances (Good & Good, 1981)" (Guarnaccia, 1993 p166) seems to fit this theoretical framework well.[13]

One study suggests that women in Peru who express symptoms of *ataques de nervios* are allowed to abandon their traditional gender roles. Instead they "leave their homes and act more independently - going to the cinema or for walks with friends was seen as a particular cure. Indeed they were often allowed to distance themselves from their husbands, to avoid both sexual and emotional services they no longer wished to provide" (Barnett, 1989 cited by Doyal, 1995: 46). Heurtin-Roberts (1993) also argues that the experience of hypertension among older African-American women is intricately connected to their life circumstances. The perception of her informants is that fear, anger and frustration brought on by pressures connected to social position, such as financial hardship, threat of crime and responsibility for the family, bring about a surge of blood – thus Heurtin-Roberts uses the lay term, '*high-pertension'* for this 'lay' definition. Her informants also detail the ways in which this illness category has allowed them to forego certain social obligations in a similar way that *ataques de nervios* may do. However, as Heurtin-Roberts (1993) warns, the fact that illness categories have become a tool for individuals to alter their circumstances should not distract us from the fact that such circumstances are related to the onset of illness, and the evidence reviewed here

---

[13] Guarnaccia (1993) notes that other illness categories such as *susto* in 'Latin America' and *fright illness* and *heart distress* in Iran are also thought to be intertwined with expressions of meaning and social circumstances.

suggests that these circumstances are likely to be those of social and material disadvantage.

Rather than interpreting this 'negotiation' as conscious acts of resistance, Leiban's (1992) discussion suggests that this phenomenon could be understood in terms of somatisation. He states that somatisation is not simply a *"conversion of distress into bodily symptoms"* (Leiban, 1992: 186) but an interaction of social and psychological processes which *"affect the perception and assessment of sensations and the expression of feelings"* (Lieban, 1992 p186). Whether such illness is used as a negotiating device, or is a somatic reaction, this provides further evidence that aspects of social position, particularly for women, can affect the experience of ill health. There appears to be little evidence that men use illness categories in the same way, although Oquendo (1994) suggests that in Puerto Rico men "may cope with such effects [of misfortune] ... by direct expression or by the use of alcohol" (Oquendo, 1994: 63). The implication is that women who may not be able to directly express their distress experience ill health as a result, whilst men may be able to express their feelings more directly or take other action to help them cope. Findings by Krieger (1990) go some way to support this idea. In her study of black and white groups of women in America she examines the connections between not disclosing or challenging experiences of racial and sex discrimination and the experience of hypertension. Her main finding is that not talking about discrimination seems to increase the risk of hypertension and that black women aged over 45 years are more likely to keep quiet about racial and sex discrimination and accept poor treatment.[14]

Whilst 'keeping quiet' may have a negative health outcome for some women, this does not necessarily help us understand the relationship between life circumstances and experience of illness in men's lives. The evidence above might suggest that men do not experience the same levels of these illness categories because they are able to express themselves better, but this contradicts a widely held assumption that in general men do not readily admit to feelings of distress and not being able to cope. In fact, organisers of the 'defeat depression' campaign in Britain felt confident enough about this to state in their patient leaflet about depression in men that the desire to fulfil a 'macho' image meant that "Most men don't like to admit that they

[14] These findings are also supported by my own which are discussed in chapter 5 of this thesis.

feel fragile and vulnerable and so are less likely to talk about their feelings with their friends, loved ones or their doctors" (Health Education Authority, c.1994: 2). In the same leaflet it was suggested that men might use strategies to cope that are perceived to be more 'masculine', such as the consumption of alcohol and drugs. Others have argued that abusive behaviour towards female partners has been a means for some men of minority ethnic status in Britain to cope with their alienation and loss of social power in a racialised society (Bryan, Dadzie & Scafe, 1985 and Mama, 1993).

Clearly these ideas cannot be generalised across all women and men, but they do suggest that there are connections between psycho-social health and the need to mediate oppressive life circumstances in some way. There is also an indication that these processes are likely to differ between women and men, and this is explored in later chapters of this thesis.

2.4.b Identity and culture as a sustaining force.

There is growing evidence that counter-power can also work through positive constructions of ethnic identity and a sense of belonging to a cultural group. Black identity in particular can provide a framework through which circumstances in an individual's life, including health and illness experiences, can be understood, and in some cases can be an organising force for political struggle (Kelleher 1996). In addition, belonging to a cultural group may provide a sense of community and safety for people of minority ethnic status (Kelleher 1996), and a sense of continuity for older African-Caribbean people (Blakemore and Boneham 1994).

Findings in America suggest that there may be positive health effects of this form of resistance. In his study of racially segregated areas in America, Dressler (1988) found an association between prevalence of one cultural group with a more positive mental well-being. He explains this by suggesting that where people of the same cultural group live together and share a similar view of life and access to resources 'lifestyle incongruity' (Dressler 1988) is mitigated. Lifestyle incongruity refers in this case to the mis-match between (black) cultural ideology and access to financial resources in segregated areas, and the measure of status by visible material possessions and behaviours of the dominant (white) population. Dressler suggests

that such a mis-match "may lead to self-doubt and to the negative cognitions associated with depression" (Dressler 1988: 87).

This finding is supported by Cohen & Wills (1985) who suggest that social network integration encourages a sense of stability and well-being. However, it must be considered that in the context of Britain at least, racial segregation does not occur so visibly as in America, and that minority ethnic groups, particularly across the life course, do not hold homogenous understandings of culture. Therefore, any cohesive communities of support are likely to be small-scale. It must also be noted that these findings are not interpreted as a validation of racial segregation, particularly as this process encourages a social, economic and physical environment that also has many negative effects on health status (see sections 2.3.b and 2.3.c of this chapter). Instead I would argue that where an integrated network exists it is a response necessitated by exclusionary power relations. What this evidence does offer is a suggestion that the very categories of exclusion, whether defined by race or ethnicity, can be mobilised as a means to mediate the effects of such exclusion.

Specific elements of what might be perceived as African-Caribbean culture can provide a form of resistance, and I will briefly discuss research that explores this in relation to health related practices. Knowledge of Caribbean island bush medicines and health belief systems is one aspect of African-Caribbean culture that might be invoked as a mediating force. Thorogood (1990) discusses the importance of relaying memories about making and consuming tonics and other remedies for the African-Caribbean women in London that she interviewed.[15] She felt "the way they experience health and illness and the appropriate ways of dealing with this are an expression of their 'culture,' their history, and their current experience as black women. In this way 'culture' can be reappropriated and seen as a dynamic interactive process" (Thorogood, 1990: 150). This suggests two things. First, recollections of bush medicine encourage feelings of belonging to a collective identity, which may encourage well-being and a sense of security. Second, claiming and celebrating cultural identity in this way may also act as a means to challenge, to some extent, the ownership and definition of their culture by more powerful groups in society. In the same way, Wong (1986) argues that the use of Creole or Patois languages in Britain

[15] Significantly it is the telling , rather than the practical use, of bush medicine that acts as a means to feel connected to a Caribbean 'community'.

by African-Caribbeans has enabled those that use it to both celebrate a collective identity whilst also providing resistance to their marginalised position through the use of language that is less likely to be understood.

Black churches in Britain can also represent sites of counter-power in several ways and are referred to a great deal by informants in this present research. Informants consistently suggested that the growth of black churches was a response to both the hostility towards black people from mainstream churches when Commonwealth immigrants began arriving after 1945, and the nature of services within the Church of England (this is supported by Sutcliffe & Tomlin (1986). Many of these churches are Pentecostal and involve services that are interactive and unrehearsed, and set up to enable the 'Spirit of God' to move among the congregation. The ownership of these churches and their similarities to those frequented in the Caribbean seems to represent active resistance and also encourages a sense of community. In addition, Sutcliffe & Tomlin argue that the emotional expressiveness of the congregation can potentially alienate an unaccustomed white observer, thus transforming the racialised power relationship.

It is not clear whether certain aspects of African-Caribbean culture are more readily invoked by women or men. Sutcliffe & Tomlin (1986) argue that compared with men, African-Caribbean women use Creole more in private situations, which suggests that men may use this as a form of resistance more than women. Thorogood's (1990) work gives the impression that it is women who connect more strongly to knowledge of bush medicine, and it may be the case that recollecting this knowledge does also re-affirm a powerful position for women who traditionally control this treatment system in the Caribbean. However, as my findings suggest, such knowledge can also be empowering for African-Caribbean men. Clearly it is not possible to make generalisations, particularly across the life course, but it is feasible that women and men might engage different aspects of their identity and culture as a means to mediate their circumstances and social position. I have explored this further in chapter 6.

2.4.c Autonomy and 'risk': problems with self-governance discourses.

Individual sense of one's ability to assert oneself and one's power in social relations is important for health promotion models which emphasise individual responsibility for health. Petersen (1997) argues that developing within the neo-liberal political paradigm that exists in Britain and other Western nations is a notion of 'self' as an "entrepreneurial individual, endowed with freedom and autonomy, and the capacity to properly care for him or herself" (Petersen, 1997: 194). This notion of 'self' has influenced health discourse so that, as an 'entrepreneur', the individual is increasingly called upon to govern themselves in a process of "endless self-examination, self-care and self-improvement" (Petersen, 1997: 194). Petersen argues that Health Promotion departments are taking on board this understanding of self, particularly in the identification of lifestyle 'risk' factors.[16] As a result there is a growing perception that an individual has a choice in maintaining their health. Inability to regulate lifestyle is seen as a 'failure'. He goes further to suggest that 'success'/'failure' in controlling lifestyle factors is increasingly perceived as an indication of 'success'/'failure' in other parts of life. This idea seems to have brought about a deceptive misuse of the notion of the power. Although the discourse around self-governance seems to offer individuals a means to control their health status, which is a potentially empowering position, the way this discourse has become embedded in powerful institutions and markets (Petersen, 1997 and Nettleton, 1997) appears coercive and creates the potential to develop a new stratification between those who have a 'healthy' lifestyle and those who do not.

A further criticism is the disregard promoted by the self-governance discourse for the complexity of health beliefs, behaviours and their interaction with social and economic circumstances. The simplistic and value-laden nature of the widely used *locus of control* model represents this to some extent. This model is founded on the understanding that individuals can choose to pursue healthy lifestyles (see Davison *et al.* (1992) and Stainton-Rogers (1991) for detailed critiques of this model). Those that are found to understand the determining site of illness to be internal are more likely to be interpreted as 'correct' because they appear to comply with the messages

---

[16] Petersen also suggests that focusing on lifestyle risks has encouraged a move in epidemiology towards studies that aim to identify such risks. Considering that 'ethnicity' and 'culture' have often been considered in terms of lifestyle, this development increases the potential for illness within minority groups to be blamed on their culture/ethnicity.

which Health Promotion advocate (Davison *et al.* 1992). Those who understand the determining site of illness to be external are assumed to be in need of health education (i.e. education that is provided by Health Promotion). In addition, those using the model often assume that high 'external' scores are synonymous with fatalism (Stainton-Rogers 1991) an idea which itself often has connotations with low education.

Davison *et al.* (1992) argue that it is simplistic to assume that maintaining an unhealthy lifestyle indicates a need for health education. Following a review of other studies which explore health behaviours, they suggest it is very rare that individuals are unaware of behavioural health risks. Instead, it reflects the co-existence of different health models (see section 2.2 of this chapter), and that the choice to maintain behaviour which may be perceived as harmful through a Health Promotion gaze, is made when the behaviour offers benefits to the individual in other ways. Instead of individuals being fatalistic then, this suggests that there is in fact an agency of choice. This is also suggested by Nettleton (1997), who argues that individuals do not accept expert knowledge (i.e. that of health professionals) wholly and uncritically, but use that knowledge as a tool, and assess their ability to use this 'tool' within their own circumstances.

2.5. Conclusions.

The review in this chapter is undertaken from a perspective which understands health and illness accounts to be reflections of different cultural values which extend beyond a purely medicalised view of how health and illness is caused and treated. This perspective is reflected in the discussion of evidence supporting this view in section 2.2. In this section evidence that accounts are constructed within specific (research) contexts is also discussed. It is argued that accounts can be sanitised versions of health and illness experiences ('public' accounts) or more idiosyncratic and uncensored versions ('private' accounts), depending to a significant degree on the context in which health and illness is being talked about. There is also a discussion about evidence that people use a variety of health beliefs to understand and describe their health experiences and that this variety may not always be captured by medicalised health measures. The choice of research tools for this study

reflects the need to explore the ways in which accounts are constructed and the kinds of health beliefs which influence these constructions. In particular, group and in-depth unstructured interview methods have been used to enable informants own accounts of health and illness to emerge. The different nature of these two interview tools also facilitates a comparison between constructions of accounts in different research contexts (i.e. group interviews vis-à-vis interviews with individuals).

The review has also explored the ways in which aspects of social position contribute to the experience of ill health among the African-Caribbean population group. Research indicates that gender, socio-economic status, 'race' and age variables influence health and illness experiences significantly. However, it has proved to be extremely difficult to isolate the effect of each of these variables as they are so intricately linked. For example, the experience of socio-economic disadvantage, which correlates positively with ill health, appears to be experienced differently by women and men, with women often faring worst, but evidence shows that this gender difference varies across the life-course. In addition, those of a minority ethnic position are more likely to experience socio-economic disadvantage, but that this again varies between women and men in these groups, and across the life-course. Minority ethnic groups then, may experience more ill health than white population groups in general, and there is evidence to suggest that experiences of racism contribute to this pattern.

The relationship between ill health and social position appears to work in two inter-related directions. Evidence described in this review suggests that whilst marginalised structural position can act as a risk factor for ill health, individuals can, and do, mobilise elements of this position in a process of counter-power, which acts to mediate and sometimes transform aspects of their marginal position, which appears to have a positive effect on health status. To explore the connections between ill health and social location – which refers primarily to an individual's gender, socio-economic and 'race' position – in more depth the study has focused specifically on the African-Caribbean group in east London. Exploring the potential gender differences in the experience of health and illness is facilitated by the inclusion of both women and men in this study. Differences across the life-course are explored by the inclusion of women and men of different generations who might be broadly classed as first-wave migrants, second-wave migrants, and British born

African-Caribbeans. The socio-economic environment in east London that the African-Caribbean population experience is characterised by high unemployment, overcrowding and lack of material goods, and these disadvantages are experienced disproportionately more by minority ethnic groups than white groups. This has meant that socio-economic status and 'race' is experienced similarly across the African-Caribbean population group and for this reason the sample of informants in this study shares similar experiences of social and economic disadvantage.

Research tools have been chosen which allow the researcher to develop a deeper insight into how social position might be linked to health status. To avoid the replication of stereo-typed understandings of how marginalised groups, particularly women and black and minority ethnic groups, experience health and illness, the methodology used in this study incorporates a strategy that prioritises informants own versions of their experiences. This strategy includes the development of appropriate means to access informants, the choice of research tools, and the approach to analysis and validation. Methodology is discussed in the following chapter.

3. DEVELOPING AN APPROPRIATE METHODOLOGY.

3.1. Introduction.

Researching a marginalised group has presented me with two concerns. First, how best to represent African-Caribbean informants without reinforcing dominant processes of stratification and exploitation and second, how to address my own position as a white female academic and the perception of myself as having different life experiences to those of the informants. In particular, I have focused heavily on the racialised power dynamics that might exist in the research relationships developed in the study and the strategies I have used reflect this focus. For example, I have used strategies of access that emphasise a collaborative approach, methods that enable informants to develop their own narratives, and analysis that is reflexive about power relationships that exist both within the research relationship, and that are expressed by the informant in relation to wider social situations.

Feminist and anti-racist researchers have been concerned with power dynamics in the research relationship and their approach to methodology has influenced that developed in this study. This methodology is discussed in section 3.2. Feminist literature about power relationships, and how my concerns about this has influenced my choice of research methods, is discussed in 3.2.a. In section 3.2.b I discuss in more detail the research methods that have been used in this study, that is the group interview and the in-depth interview, and how these were conducted in the field.

As outlined in chapter 2, I have taken a social constructionist approach to how health and illness is reported. In order to understand more fully how accounts told to the researcher are recounted, I have explicitly discussed the processes of gaining access and the conduct of research in section 3.3. I have detailed the process of accessing informants at different phases in this research, with reference to the way that offering and withdrawing access reflects forms of empowerment for participants. In particular, the development of trust and rapport between researcher and researched is discussed,

with the understanding that these dynamics are important in understanding the construction of health and illness accounts. Lastly, I have outlined in section 3.4 the ways that material has been collected and recorded, and the process of interpretation that has been central to the analysis in this research.

3.2. A feminist methodology.

A key concept of feminism is the acknowledgement that researchers are participants in the world that they are researching, and as such bring their own common-sense understandings of the social world as they have experienced it to the research relationship. This actively challenges an assumption in neo-positivist research that the research relationship can be conducted with neutral detachment, and that collection of material and analysis can be 'objective' (England, 1994). Instead, feminists consider that the research relationship is constructed by existing social power relationships (Herod, 1993) and creates a further power dynamic through the authority of the researcher over the researched. Therefore, the researcher is understood as an active instrument in the production of research material and in analysis (Herod, 1993 and England, 1994). Attention to the position of the researcher is of particular relevance to this study because of the 'race' dynamics that exist between a white researcher and black minority informants.

In chapter 1 I suggested that feminist critiques have helped precipitate a shift in contemporary geography towards a more critical analysis of the ways that social categories are constructed and understood. Not only does this problematise the position of researchers who are themselves implicitly embedded within structures of power but also the role that methodology has in reinforcing social hierarchies of power. The ways that informants are represented has received particular attention. McDowell (1992) argues that feminism has a political purpose: to re-construct our notions of women in a way that can be empowering. She argues for the development of research relationships that enable informants to discuss their *personal* experiences, and for the researcher to represent these experiences in an accurate and valid way. The political motivation of facilitating empowerment in some form is an ideal that is at the core of this research, although not focused singularly on empowering women. Anti-

racist researchers also questions the way in which research traditionally represents black and minority ethnic groups. For example, writers such as hooks (1990) suggest that those whose 'race' position places them at the margins often have their voices appropriated by those at the centre, a perspective which echoes feminist arguments about representations of women in research. In response to concerns about positionality and representation, I have developed a methodology in which it is possible to pay attention to power structures, and represent informants' own constructions of their experiences and the position of the researcher. Unstructured interview tools were considered to be the most appropriate way of researching and addressing these concerns, and these are discussed in 3.2.b.

3.2.a Addressing power relationships in research.

Earlier feminists such as Oakley argued that the best way to explore the world of the informant is "when the relationship of interviewer and interviewee is non-hierarchical and when the interviewer is prepared to invest his or her own personal identity in the relationship" (Oakley 1981: 41). In response to these concerns, feminist researchers have used methods that attempt to transfer some of the power invested in these relationships to the researched by understanding the researcher's role as that of 'supplicant' (England 1994). Taking up this role is based on the perception that the researcher actually becomes *dependent on the informant* for access to their knowledge, which offers the informant a position of power. Through this approach it is assumed that researchers can develop relationships with the researched that are less hierarchical, more interactive, and based on mutual respect and empathy. Alongside this feminists have incorporated a reflexive approach to their research. This allows them to be more aware of how the dynamics of the research relationship alter the kinds of information that are offered by the informant. Such critical introspection might "lead to insights and new hypotheses about the research questions" (England 1994: 82). It may also encourage researchers to address assumptions they hold themselves, and to ask interviewees to reflect upon their assumptions (Herod, 1993). This allows the researcher to alter research strategies where reflection suggests they are not workable or appropriate. I would argue that reflexivity is enhanced by attention not only to verbal discourse, but also to non-verbal expressions. Awareness of these expressive forms can offer insights into the dynamics of the relationship between

researcher and researched that are not clear in spoken expressions. However, non-verbal expressions are much more difficult to record and interpret and in this study it is only my *impression* of these forms of communication that are used to confirm my interpretations of what is being spoken.

England (1994) argues that reflexiveness about power relationships in research does not *remove* the dymanics. Instead, she advocates strategies that might act to counterbalance power within relationships. However, she highlights the views of other researchers that taking a 'supplicant' approach may actually submerge the inherently intrusive and exploitative nature of ethnographic research, therefore creating a paradox for researchers who want to use their research for political action: in striving for material with which to transform situations, the researcher disrupts the lives of informants, and in some cases can betray them. Taking a 'supplicant' approach then, which may demand a more personal commitment from the informant, can actually expose the informant to greater risk than more traditional approaches to research might do. So by striving to achieve a more ethical balance of power within the research relationship, feminist researchers are confronted with the unethical possibility of exploiting those with whom they form such relationships. This begs the question of whether we should be doing the research in the first place. England (1994) argues that we should, but that researchers should approach research power relationships by being open about their own position and perspective. My own position is less sure. I have agreed with the ethical principles of addressing power dynamics in research, and have attempted to counter this through my own approach to taking a supplicant position. This has rested in particular on the development of a two-way relationship between researcher and researched, which itself rests on the efforts that I have made in the field to develop a sense of trust between informants and myself. This has required that I be available and answerable to questions and challenges about the research and my own position that have been made. In my analysis I have taken a reflexive approach, particularly regarding my position as a white female. However, I am left with the knowledge that despite efforts to the contrary, informants have not, individually, benefited from the research process so far, although perhaps there might be more general benefits if this study influences policy development in agencies with influence over health and welfare of African Caribben populations in East London. Not only

this, it is clear that some community groups that participated have felt exploited by researchers in the past, and therefore the outcome of my work may compound this.

Taking a feminist approach to research has required the use of research methods that address the concerns about positionality and representation that were outlined above. Alongside strategies of access and collaboration, which ensure that informants are more able to participate as partners with, rather than subordinates to, the researcher, the use of unstructured and semi-structured interviews have made it possible to gain an insight into the views and knowledge of participants, and the processes of how informants' health and illness discourses might be constructed.

3.2.b Method of research: unstructured interviews.

An 'interview' is increasingly used in our world as a means of accessing information and an insight into people's worlds (Holstein & Gubrium 1997). However, approaches to conducting this verbal interaction vary between, at one of the spectrum, a positivist position, and at the other, a radical social constructionist position. Positivists approach interviewing as a means to 'get at' the 'reality' that exists in an informant's world, whilst radical social constructionists refute the existence of a free-standing 'reality' to be got at, and instead view the interview as an interaction "in which both participants [i.e. the researcher and informant] create and construct narrative versions of the social world" (Miller &Glassner 1997: 99). Criticism of the notion that interview material can provide a mirror image of the social world, as in positivist research, is wide and exemplified in the discussion about feminism and anti-racist research which identifies the implications that power dynamics can have for the research relationship. However, this does not mean that the opposite view of radical social constructionists needs to be adopted in it's entirety. Whilst the interview is a *construction* of narrative, this does not mean that knowledge of the social world beyond the interaction cannot be obtained. In fact, Miller and Glassner (1997) argue that it is in the context of non-positivist interviews "that 'inter-subjective depth' and 'deep-mutual understanding' can be achieved (and, with these, the achievement of knowledge of social worlds)" (Miller & Glassner 1997: 100). This middle-way position is one that is adopted for the purposes of this research. In one respect, interviews have been conduted in order to 'find out' about informant's worlds and views, thus assuming that some of the

interview narrative at least, reflects parts of informant's worlds which are maintained outside of the interview context, and in particular, their experiences and beliefs about health and illness. I used semi-structured group interviews to gain an initial insight into the experiences of African-Caribbean informants. Themes which emerged from these group interviews were then explored in unstructured in-depth interviews with individuals. However, I also accept that informants will respond to interviewers based on their perception of who the interviewer is. In this study I have paid much attention to perceptions of my social position (i.e. my gender, 'race' and class) and the social distance that may be perceived to exist between myself and informants.[1]

The concern with how health and illness accounts might be constructed according to these social dynamics has led me to examine the accounts that emerged from the two research methods used in this study, group interviews and in-depth interviews. Each of these research tools, although incorporating the same qualities of interviewing, capture very different research relationships which appear to have had different effects on the health and illness accounts constructed by informants. The group interviews were conducted through the medium of question items from structured questionnaires, and this has enabled me to explore the influence that this research tool might have on the health and illness accounts that are produced. Thus interviews have been understood as both the *tool* and the *object* (Fontana and Frey, 1994). This approach to research methods and health and illness accounts has been particularly useful in developing a better understanding of public and private health accounts, which were first explored by Cornwell (1984) (see chapter 2). As a result the discussion of substantive material in chapters 4, 5 and 6 reflects not only the material produced by these different research tools, but also the role that these different tools have in the construction of that material.

3.2.b.i Group interviews.

Group interviewing as a method was chosen for this study for three main reasons. Firstly, group interviews offer an effective way of doing research that is responsive to both feminist and anti-racist concerns. Unstructured group interviews allow

---

[1] However, other considerations that are not addressed in this study may also be significant, for example, the time at which an interviewer appears in a person's life.

participants to "explore the issues of importance to *them*, in *their own* vocabulary, generating *their own* questions and pursuing *their own* priorities" (Kitzinger 1996: 37; emphasis added), therefore enabling marginalised voices to be heard more effectively. This method has the further potential to achieve a more equal power relationship between informants and researcher by enabling informants to control the direction of the interview in a participatory relationship with the researcher. In addition, evidence suggests that group interviews offer the potential for participants to learn and reflect on what is being discussed (see for example, Burgess *et al.*, 1988a; Goss and Leinbach, 1996), thus offering a more self-generated form of empowerment.

Secondly, group interviews allow participants to negotiate the 'stories' and accounts they produce among themselves, offering a valuable insight into the knowledge and values the group has drawn upon. *Group interviews* then, seemed an appropriate means of gaining some insight into a collective knowledge about health and illness that was specific to informants involved in this study. The mediation of accounts by a group of peers, rather than the researcher, also means that experiences are more likely to be represented through language and concepts that are part of informants' daily life (Goss and Leinbach, 1996). This is distinct from accounts that are produced in researcher-informant only interactions which may encourage informants to represent their experiences in ways that they perceive to be familiar to, and expected by, the researcher. It is understood, however, that the accounts constructed within group interviews are more likely to produce 'public' accounts that reflect a collective understanding of what is moral and acceptable.

Thirdly, as part of a strategy to gain access (see next section), the group interview was also used as a means of introducing myself and the research to informants who were asked to participate in in-depth interviews following the group interview. This strategy meant that by asking informants to participate in two interviews they were asked to invest a great deal of themselves in the project, often with little real return and the potential risk of exposure. There are clear ethical dilemmas to this, which I attempted to address by ensuring that participants were willing to participate and that they were informed about what the interviews involved before they agreed to participate. However, in the case of group interviews this strategy was sometimes compromised

by the need to involve community group leaders in accessing community group members, and this is discussed in the next section of this chapter.

The group interviews were conducted through the medium of question items from self-reported health measures, the choice of which is discussed below. The aim was to gain an insight into the groups' attitudes towards, and beliefs and coping strategies about health and illness by asking informants to respond to the question items on paper, individually, and then to discuss the questions in a group. [2] Informants were asked to complete the 'questionnaire' primarily so that they would be able to comment on the thought processes that the question items prompted. The written responses were not disclosed to the group, and where informants were not comfortable in recording their responses they were not put under any pressure to do so (see section on 'accessing informants for group interviews' in 3.3.b). Only in the case of 'Lenny' was an informant's individual responses to the questions made known to others in the group. In this case, because of the difficulties Lenny had in completing the questionnaire without his glasses, the community group co-ordinator helped him by reading out the questions to him, necessitating Lenny to reply verbally. It is likely that the public nature of Lenny's responses influenced the actual accounts of health and illness that he used to respond to the questions. Lastly, where possible group interviews were conducted with women and men separately, and with different age groups, in order to explore whether differences between the collective health and illness accounts of each group might emerge.

Choice of questions.

The discussion in chapter 2 showed that women and men are likely to report ill health differently in the categories of psycho-social illness or malaise symptoms. This research did not aim to collect epidemiological information in any systematic way, but the review in chapter 2 had raised questions about how individuals may understand and respond to questions used in systematic surveys. It was therefore appropriate to select question items that measured self-reports of these categories and discuss them with the respondents in order to explore whether women and men discussed these problems differently. It is also the case that structured questionnaires use question

[2] This strategy has already been used effectively by Eyles and Donovan (1986).

items which assume a good deal of consistency in response between individuals which neglects the variation of affective variables amongst individuals and how those variables actually inter-relate. Question items in structured questionnaires do not always reflect a wide spectrum of the ways in which health and illness is experienced and understood, and can often be based on a male, white, bio-medical perspective of ill health. In some cases however, the validation of these instruments has focussed on applicability for ethnically diverse populations (see, for example, Nazroo, 1997a, 1997b, and Rudat, 1994). The question items included in the 'questionnaire' put together for the group interview were chosen to reflect both the standard questions used and those being developed for black and minority ethnic groups in order to provide material for discussion. The questions were chosen following searches of the ESRC archive for questionnaire measures, the CD-Rom Medline, and Bowling's (1991) comprehensive listing of measures. This search elicited several sources from which to draw questions, and the final selection of questions were drawn from the MOS Short-Form Health Survey (SF-36) (Medical Outcomes Trust, 1994), the Black & Minority Ethnic Groups in England Health & Lifestyle Survey (BMEGHALS)[3] (Rudat, 1994) and the 1991 Population Census.

A small number of question items were selected from these sources in order to allow more time for discussion during group interviews. Questions chosen included self-assessment of health status, activity affected by health, emotional well-being, care-seeking behaviour, social support and links between health and life events. Questions were word-processed and printed in a readable size and in a format that could be self-administered. Some of the questions considered were originally designed for self administration, but others would normally require an interviewee to disclose information to an interviewer. For this exercise, I converted the questions to a 'self-administered' format, so that respondents would not need to disclose their responses to the group. For example, parts of the BMEGHALS were altered slightly to transfer it from an interviewer-completed form to a self-completed one. For example, "How do they rate their health?" became "How do you rate your health?" Changes to the format of these questions, might mean that they would not elicit exactly the same responses as in a systematic survey, but as I was not making direct comparisons with other survey

[3] This questionnaire was designed to provide comparison with the Health & Lifestyle Survey.

data this was not important for this research. These 'questionnaires' are shown in appendix I.

Numbers of participants in group interviews varied, although I aimed for 5-8 people. As will be discussed in the following section, the strategy I used for gaining access to informants meant that I could not always determine how many people would be participating until the interview actually took place. Most group interviews lasted from one hour, to one and a half hours, although where access was more fraught (i.e. group interviews C and F) interviews were shorter than this. The planned format of the group was to allow members to complete the question items, and then to conduct a discussion of the questions. In this discussion I often used an 'aide memoire' (Burgess 1984) which I used primarily as a reminder of aspects of the questions I thought useful to explore. In particular, the memoire noted questions around defining and measuring health, effects on activities of ill health, possible influences on perceptions of ill health and the kinds of social support used (see Appendix II). In practice format was variable between groups, depending on the reservations held by informants and their willingness to discuss issues of health. Group C completed the whole 'questionnaire' individually and then had a (limited) discussion about the items, Group F did not complete the items but discussed the questions together as they read through them, whilst group E became so embroiled in their discussion of experiences of health and illness that they were completely diverted from the 'questionnaire' and they offered to do a second group interview that focused more specifically on the question items. The discussion in group interview Bii did focus on the question items, but prior to this an impromptu group interview (Bi) took place, which provided further material for this study. During discussions of question items, I drew out references that informants made to social position as it linked to ill health.

In view of this approach to group interviews, I have made a distinction between the form of these groups and the 'once-only groups' (Burgess *et al.*, 1988a) or focus groups. It is worth making this distinction because the growing popularity of the time- and money-efficient 'focus group' appears to have spawned 'how-to-do' guides that do not explore distinctions between groups or the epistemologies behind them. Burgess *et al.* define 'once-only groups' to be "where the interpersonal relationships of the members are secondary to the discussion of the product or stimulus material"

(Burgess *et al*, 1988a: 311). Essentially I have conducted interviews around a 'stimulus material' but interpersonal relationships have been very much the focus of this study too. Burgess *et al.* describe another form of interview, the 'in-depth small group,' that meet on several occasions and where analysis is concerned with how "the content of the conversations is intimately connected with the character of relations between the group members" (Burgess *et al*, 1988a: 311). This appears to define the groups conducted in this research more closely, although the group interviews conducted within this study have only taken place on one occasion (with noted exceptions). I refer to these interviews then, simply as 'group interviews.'

3.2.c.ii In-depth interviews.

Group interviews are useful for gaining some insight into the experiences and beliefs about health and illness of a group of people, and into the collective representation of those viewpoints, but they are not the most appropriate tool for exploring the perspectives of individuals. This might be explained by the tendency for groups to produce 'public' accounts of health and illness (see discussion of Cornwell's work (1984) in chapter 2, section 2.2), which reflect only the acceptable and valued beliefs and experiences of health and illness held by the group members, and by society in general. These accounts are useful to explore, but it is possible that individuals can experience health and illness in ways which are not perceived as acceptable to the group and, as a result, may not be made voiced within the group. There may be exceptions to this, for example, where group members know each other well enough to discuss personal views, and where there is sufficient trust in the interviewer to disclose these. In general however, interviewing individuals alone allows the researcher to explore more fully informant's experiences which may conflict with acceptable 'public' accounts, producing what Cornwell (1984) calls 'private' accounts.[4] In-depth interviews with individuals also offer the researcher the potential of exploring in more detail the processes involved in recognising, acting on and understanding symptoms of ill health through 'private' accounts. Therefore, informant's personal experiences of health and illness have been explored in this study through in-depth interviews.

---

[4] Public and private accounts are explored more extensively in chapter 4.

Interviews were conducted in an unstructured form. This enabled informants, as far as possible, to recount their health and illness experiences in a way that was not directed by the researcher. Taking a less directed approach had the aim of minimising the possibility that the interview would be structured by assumptions held by myself and ensured that informants' own voices would be heard, thus going some way towards achieving the supplicant position I have adopted for this study. In practice, however, a completely unstructured interview is hard to achieve, and it was the case with some informants in this study that they expected some form of direction from the researcher. Therefore, I constructed an 'aide memoire' (Burgess, 1984) that provided me with some key questions that I used mainly as a back-up in interviews with informants where some direction was expected from the interviewer. The aide memoire was also used when an informant did not elaborate on the points that they were making, and where it was difficult, therefore, to pick up threads from their statements. In these situations the questions in the memoire helped me to maintain the flow of the interview. Questions in the memoire were grouped according to the following themes: communicating ill health, understanding health and illness, social congruity, strategies of coping and Caribbean ways of responding to ill health. The questions were developed from the themes emerging from the group interviews, and these questions are outlined in Appendix III. It is important to clarify that the questions written here were viewed only by myself, and were not verbalised as they are written, or discussed in any systematic way. Instead they acted as a reminder of the themes I thought to be of relevance which were then brought into the interview when I felt it was appropriate to the context of discussion. It was often unnecessary to look at the memoire at all, particularly later on in the research when I was becoming much more finely tuned to the avenues of discussion that might be relevant to explore.

In some cases informants had participated in both group and in-depth interviews which had implications for the conduct of the in-depth interview with such an individual. In the case of many, this was a positive aspect of the research strategy, as it meant that informants were more comfortable with the interviewer and with sharing their views, and had often reflected on their experiences in the intervening period between group and in-depth interviews. In some cases it did present difficulties where informants did not discuss health and illness beyond public accounts. This meant that they merely re-iterated what they had stated in group interviews, thereby creating some frustration for

them. In addition, where participants of in-depth interviews had not taken part in group interviews or, by virtue of the access routes I used (see discussion in phase 4 in 3.3.b), had not received a full background about the project, their reservations over talking about personal experiences were often stronger, although, this did depend on the personality of the informant too.

3.3 Data collection.

As was outlined in chapter 2, the target sample group for this study includes African-Caribbean women and men of various ages and generations in order to explore how health and illness might be experienced by different groups within the African-Caribbean population. The primary means of access to these target groups has been through community groups and the reasons for this are outlined in section 3.3.a below.

The following section, 3.3.b, describes the different phases of access that are involved in this study. This discussion reflects my concern about the power relationships that I felt existed between the researcher and informants, particularly the racialised dynamics and the social distance between myself, as a health researcher, and informants, many of whom had experienced forms of social and material disadvantage. My sensitivity to these dynamics has led me to focus on the strategies which attempt to 'even out' the discrepancy between the social location of informants and myself to some degree. Taking a 'supplicant' position has already been discussed in section 3.2 and this formed part of the 'evening out' strategy. Other strategies included spending time with members of community groups outside of the formal interviews, ensuring where possible participants' willingness to become involved in the project, and their inclusion in the validation process through feedback groups. I also prioritised the development of *trust* and *rapport* within research relationships which I felt, when in place, would help break down barriers that are formed when social distance is perceived. It should be emphasised that it was never assumed that social distance would be narrowed to any degree by this strategy, but that where dialogue could be facilitated by this, informants would feel able to participate in the study and give voice to their views and experiences.

My discussion of access to informants reflects the way that it is constantly negotiated in the field. As a result of my prioritisation of power dynamics I have understood this to be an expression of counter-power, a reflection of the power dynamics that existed between myself, a white, female health researcher, and the African-Caribbean informants with whom I came into contact. This approach to understanding the research material produced in this study is important to be aware of throughout my discussion of how I have interpreted this material in chapters 4, 5 and 6. Racialised dynamics in particular, and the effect that these have on the accounts constructed by informants, have been prioritised and this is reflected not only in the discussion of substantive material in chapters 4, 5 and 6, but also in the discussion below regarding the negotiation of access to informants in this study.

3.3.a Sampling through African-Caribbean community groups.

Organized African-Caribbean community groups in east London were chosen as a primary means of access to respondents in this research. This sampling method was appropriate for several reasons. Firstly, community groups offered the potential for meeting a number of individuals in the African-Caribbean population group of east London in a setting which was separate from a health service location, so that participants in the study would not necessarily be ill or receiving care. Secondly, by approaching groups that target African-Caribbean communities in east London specifically, I was able to overcome the problem of how to meet individuals who saw themselves as 'African-Caribbean.' It was assumed that members of such community groups identified in some way with the term 'African-Caribbean', although the way individuals might interpret this term would undoubtedly be variable. Thirdly, community groups that met regularly offered a forum through which I was able to develop a relationship between myself and community group members that allowed open and frank conversations about the research and their reservations about it. This facilitated the development of a rapport with informants which was part of the 'evening out' process discussed above, therefore providing a grounding for more open discussions during the group and in-depth interviews. Attending community group meetings prior to group interviews encouraged the development of rapport. Fourthly, working through community groups meant that there was a potential to conduct the

group interviews in the group's meeting venue. This was useful in a practical sense, but also because it would enable me to conduct group interviews in a space that informants belonging to the community group would already be familiar with, thus encouraging them to feel more 'at home' during the interview. Locating group interviews in familiar surroundings did appear to encourage a more open and less formal discussion in some cases.

All the groups that I approached specifically targeted the African-Caribbean communities in Hackney and Newham, with the exception of groups providing services to young people. The reasons for approaching other groups will be discussed later in this section. I also aimed to select groups that did not target individuals experiencing specific illnesses, such as lupus or sickle cell disorders. This was mainly because evidence for gender differences is clearer in reporting of minor mental health problems and 'malaise' symptoms, and I felt, therefore, that it was not appropriate to include individuals in this study experiencing more chronic illness. The exception was one Christian community group that offers support for the prevention of mental health problems. This group has been included because it offered a means to explore the influence of religion on health beliefs and the experience of mental illness in the African-Caribbean community. Beyond these criteria I also aimed to include women and men from a cross-section of ages. I did not specifically aim to include a cross-section of informants across categories of socio-economic status. This was mainly due to the difficulties in categorising socio-economic status for minority ethnic groups (see discussion in chapter 2, section 2.3.a). In addition, the disproportionate levels of material disadvantage experienced by this population group in Hackney and Newham suggested that I would come into contact mainly with individuals experiencing some level of socio-economic disadvantage, and this was borne out.

The strategy of using community groups as a sampling method has implications for the ways that the findings should be understood. Not all people feel the need or motivation to join community groups and it might be argued that such groups are not within the everyday experience of the majority of British people. This implies that those who have joined, do so for a particular reason. It may simply be that a friend or family member has invited them and they have continued to attend. Or that the group offers a particular service which the user wishes to utilise. However, it may also

indicate that an individual has experience of or is experiencing difficult personal circumstances or life event(s). Or it may be that an individual wishes to converse with others. In the case of groups specifically for women or minority ethnic groups there is also the likelihood that 'joiners' may be seeking solidarity with others with similar experiences, or there may be political motivations for joining. From in-depth and group interviews it was clear that for many informants in this study the groups provided support in their lives, whether practical, emotional or spiritual in nature. This does not imply informants in this study are in more need of support than other 'non-joiners', but that the motivation that brings them to the groups may also influence their decisions to participate in the research, and possibly their perceptions of health and illness experiences.

The process of gaining access to informants was complex, but it is possible to discuss four distinct phases. The first phase involved gaining access to community groups, phase two was concerned to access community group members themselves, the third phase aimed to select community group members for group interviews, and the fourth phase aimed to select individuals within community groups for in-depth interviews. In this last phase I tried to select informants who had participated in group interviews where possible. It is useful to discuss these phases in turn as gaining access, in the context of this study at least, is often directly related to the social locations of both the researched and the researcher, and may influence the material produced during interviews. In the following discussion I emphasise how developing trust and rapport is a crucial element in the process of gaining access.

3.3.b Negotiation of access: the importance of gaining trust

Strategies of access in this study were not standardised. Instead, I aimed to be responsive to the nature of the community group and the working practice of group co-ordinators, and changed my strategy accordingly. This offered a greater likelihood of gaining access to community groups (phase 1). Also, by working to find a way to 'fit in' both my presence and the research within the groups' existing structures, through discussion with co-ordinators, I was more likely to gain access to community group members (phase 2) and subsequently be able to select informants (phases 3 and 4). However, 'fitting in' was not simply a case of finding the most appropriate time and

means to approach individuals. This approach also communicated to the co-ordinators that I was sensitive to the needs of the group and this in itself helped promote a sense of trust. This was particularly important as group co-ordinators acted as 'gate-keepers' to group members and in most cases were advocates to my personal integrity and professional demeanour. Therefore this initial sense of trust provided a crucial grounding on which I was able to build relationships with group members.

Phase 1: accessing community groups.

Finding African-Caribbean community groups in Hackney and Newham was undertaken in various ways. A directory of community groups in Hackney and listings of community groups held by the King's Fund were the starting point. Also important were recommendations from staff at East London & the City Health Authority's Health Promotion and Public Health departments and Social Services personnel who worked in the two boroughs, and recommendations from community group co-ordinators themselves. Groups for African-Caribbeans in these areas predominantly targeted women and the elderly.[5] Although groups for the elderly catered for elderly men, men under the age of 55 years appeared to have little provision in the way of community groups, except for groups offering services for those experiencing mental illness. This created problems in accessing African-Caribbean men, particularly in the age range 30-55 years, reflected in table 3.3, which details characteristics of participating informants. Reasons for this apparent under-provision are speculative. It was clear in conversations with community workers that some African-Caribbean men in this age range did meet socially on an informal level, for example, at Domino Clubs[6] and Dance Hall. These venues may provide men sufficiently with the social interaction that they require; alternatively men at this stage of the life-course may simply not perceive the need to attend formal community groups. However, the low numbers attending groups may also reflect a disaffection that may work in two directions. Statutory agencies may be failing to identify the needs of African-Caribbean men and how to meet them, whilst experiences of racism may have encouraged African-Caribbean men to distrust service provision available to them. There may also be a sense that social meetings of this kind are more appropriate for

---

[5] This does not include groups that provide services to individuals experiencing a specific health problem.

[6] Locating a domino club was attempted but abandoned when I was unable to find someone able to introduce me to such a group.

women. In the one group that did have men of this age group attending - a church group - men declined to take part in the study.

Accessing young African-Caribbean women and men, particularly those under the age of 25, was also problematic, for different reasons. It was not possible to find community groups that specifically targeted African-Caribbeans of this age group. Instead, informants under 25 had to be accessed through youth groups that provided tuition and supervision for a range of activities for young people in general, living within these localities. This may suggest that the identity of young black people, who are born and brought up in Britain, may be changing. This challenges the relevance of the 'African-Caribbean' category for their cultural and political identity. The absence of groups targeting young African-Caribbeans may also reflect the difficulties faced by service providers in trying to identify the needs of this group. Using these created problems in knowing who to approach and select, and the co-ordinators role in addressing this is discussed later.

I was not able to approach community groups in systematic waves. My knowledge of which groups existed, who to contact and how to contact them built up over a period of 18 months, and I was making contact with groups continually over this period of time. This consequently meant that whilst I was at the fourth phase of access with some community groups, I was also at phase one with others. I contacted community groups initially by letter sent to co-ordinators of the groups. These outlined the research and requested an informal meeting with the co-ordinator to discuss the possibility of group involvement in the research. These meetings were important because they removed the distance between researcher and research that postal and telephone communication imposed.

However, these letters were rarely responded to. This may have been because, in the context of a busy office environment, letters are often left unanswered where they are not of immediate importance, or where it may have been difficult to reach an immediate decision. This necessitated follow-up telephone calls to co-ordinators. These conversations were much more productive and offered the co-ordinators a chance to ask questions about the research before committing their group to participate and setting up a meeting with me to discuss how I might conduct my work. Due to the

low response rate to letters and the subsequent length of time taken to schedule meetings, the last few co-ordinators of community groups were contacted by telephone alone.

Of a total of twenty-eight groups that were approached through their co-ordinators, only in eight cases was access to group members established. Reasons why a large number of groups declined to participate are various and not always clear. In two instances the groups I approached were in the process of closing down. Co-ordinators of seven groups explained that their groups were not attended by individuals who fitted the criteria that I had outlined. These cases occurred mostly towards the end of field-work when I wanted access to individuals of a specific age or gender. For eleven of the groups approached, the reasons for declining to participate are less clear. Some did not reply to my letters or return my telephone-calls, therefore it is difficult to ascertain their reasons for doing so. The remaining co-ordinators did respond but were not explicit about their reasons for declining to take part.

The views of co-ordinators that did decide to participate might offer some insight into why others were reluctant to commit their groups. This material implies reservations might be explained, at least in part, by a perception that health research does not directly benefit those that have been researched. There may also be a perception that the needs of African-Caribbeans have a relatively low priority for health professionals and local social services. For example, field-notes record a discussion with one co-ordinator who was concerned about the way previous researchers have used her heavily researched group. I noted that she felt *"little was ever given back to the group, as far as she could see"* (field-notes 17.6.96, line 30), suggesting a sense that the group had been exploited. As the field-notes go on to record, the discussion developed to express grievances about the lack of support and provision of resources from the community and social services. This might suggest that the exploitation the co-ordinator refers to earlier is perceived to be connected to the alienation of the community group within the borough.

> "Diane seemed very concerned that little was ever given back to the group, as far as she could see. Once she got started, Diane had a lot of grievances she wished to voice – about researchers, social services, and lack of community

support."
Field-notes 17.6.96. Lines 30-33.

The perception that research and treatment by professional agencies are connected was echoed by an east London African-Caribbean mental health worker. During an informal discussion he argued that despite the large amount of research on mental health issues among African-Caribbeans, findings only seemed to serve the agendas of white professionals, rather than to bring positive changes to the lives of those researched (see extract below).

> "He gets a lot of people wanting to do research who often don't have anything set in their minds. He felt African-Caribbeans are very well researched in mental health ... and he mentioned ... multi-ethnic forums whose recommendations are based on pigeon-holing because he felt that's what white professionals want to hear. After showing [research findings] to service users he found that they thought it 'old hat' and had heard it all before."
> Field-notes 25.5.97. Lines 59-64.

As the same extract records, he argued that this perception of research was shared by service users, whose opinion about other research findings was that "*they thought it 'old hat' and had heard it all before.*" This suggests that this key worker at least would question the merits of participating in health research.

It is not known whether similar perceptions of health research helped to inform the decisions of others who declined to participate. Whether or not this is the case, such perceptions consolidate the argument for using strategies of access among those who *may* feel they have been previously exploited. As a result, in the context of this research I have aimed to encourage an environment where these views can be discussed openly, and where I can work to satisfy the informants needs as well as those of the study. In reality it may be that this aim can never be fully realised, particularly where informants are asked to 'give' a lot, and where research with theoretical, rather than practical, outcomes can 'give' little back to informants lives directly. I have felt it vital, therefore, to incorporate these views into my findings, in an attempt to offer a channel through which these views can be expressed.

Of those groups that did participate, access was not always fully established during the telephone conversation. It seemed to be important to 'check me out' before fully committing the group to participation. Therefore the first face-to-face meetings were

often a way for co-ordinators to gauge whether I was to be trusted as well as to discuss what involvement in the study might entail. My strategy for gaining trust was to take up a 'supplicant' role (see section 3.2.a). I aimed to encourage an open discussion about the research project and the issues it would address. I also talked about some of my own concerns about the research, particularly the effects that my own 'race' and gender position might have on interviewing. This openness was reciprocated by co-ordinators, often leading to frank discussions about issues of 'race', health research and the politics of the community group. In all cases this was a successful strategy: it enabled me to access group members, and provided the basis for research relationships within which access could be continually negotiated successfully.

Table 3.1 outlines details of those community groups who did agree to participate in the study. The table reflects several interesting points. Firstly, the contrast in numbers of groups targeting African-Caribbeans in Newham and Hackney is reflected in the fact that only one out of the eight participating groups is located in Newham. Secondly, although I was able to find groups targeting different age groups of both women and men, as discussed above, middle-aged men did not regularly attend these groups. Thirdly, most groups aimed to provide social and leisure activities, although some provided health and welfare services on occasion. I have also included some detail about group members, ranging from their backgrounds to the collective make-up of the group. This description is limited however, by the difficulty in generalising about what is essentially a group of individuals. Table 3,2 and 3,3 list group and in-depth interviews according to the community groups that informants belonged to. Cross-referencing between these tables will show that some groups and their members participated in the study to an extensive degree (for example, community groups 1, 2, 3 and 4) whilst other groups' participation was more limited (for example, community groups 7 and 8). Reasons for this are explored below.

Phase 2: accessing group members

Access has to be continually negotiated (Burgess, 1984) and some individuals may never offer anything more than partial access, whilst others may be more open from the beginning of the research relationship. Such degrees of access cannot always be measured by time or quality of the research relationship, and although the approval of a co-ordinator was a crucial step towards accessing group members, it did not always

Table 3.1. Participating community groups and their characteristics.

Community Group	*Location*	*Target Age* ***Group***	*Gender Group*	*Activities*	*Other details*
1	Newham	50 years and above	women and men	leisure activities, celebration meals, dances, outside speakers, visits from nurses and complementary medicine practitioners	members mostly retired
2	Hackney	all ages	women and men	services, spiritual advice, lunch, fetes, fund-raising events	members often had previous experience of mental health problems
3	Hackney	all ages	women only	informal evenings, dinner, trips to theatre/ shows	members were all in professional employment
4	Hackney	50 years and above	men only	informal meetings, lunch, advice about health and welfare if required	members were all retired
5	Hackney	teenage – 25 years	women and men	informal meetings, sports and leisure activities	members mainly of school/college age not exclusive to African-Caribbeans
6	Hackney	teenage – 25 years	women and men	informal meetings, leisure activities, outings	members mainly of school/college age
7	Hackney	teenage – 25 years	women and men	tuition provided for a range of musical instruments and performance	members did not meet at venue other than in lessons
8	Hackney	all ages	women and men	informal meeting place, advice about housing	Members from variety of backgrounds not exclusive to African-Caribbeans

guarantee it. The importance of co-ordinators approval to group members was variable both between and within groups, thus strategies of access varied at a group and individual level.

As a general strategy I aimed, where possible, to meet group members informally during their drop-in sessions at the community groups. The purpose of this was similar to the first meeting with group co-ordinators: to establish trust and rapport. Where such informal conversations were possible, trust and rapport was built on allowing group members some access to knowledge about my life beyond the 'researcher' role. By allowing this access group members were able to establish connections between us in personal circumstances and experiences, as well as to understand my personal interest and motivations regarding the research project. My experience of living in the Caribbean was often crucial in making these kinds of connections.

How this strategy was conducted depended largely on what fitted the set-up of the community group meetings and the individuals who attended. Of the eight groups who participated I was only able to meet members of four of the groups prior to group or in-depth interviews taking place. In the case of community group 1 I was able to attend drop-in sessions several times. However, it proved very difficult to engage in conversations with male group members whose attention was taken by playing dominoes. I gave an informal talk prior to group interview A, with the aim of clarifying what the interviews would involve and what issues the research was aiming to address. This talk was only attended by women and largely because of this, it became quite an involved discussion particularly around women's experiences. As a consequence this discussion has been included as material for the substantive part of the thesis (referred to as *preliminary discussion to group interview A*).

This approach was not appropriate for community group 2. This group mainly provided Christian services, lunches and spiritual guidance for group members, and this more 'practical' orientation meant (unobtrusive) conversations were only possible during lunch. In addition many group members had experienced mental health problems in the past, and some found conversations relatively difficult. In this context, an approach that enabled me to be present during lunch-times over a longer period of time was devised: for eighteen months I worked one day a week at the community

group as an administrative assistant. This did enable me to build a good rapport with all group members, and established trust that allowed a greater propensity for depth during interviews.

This strategy is useful to explore as a means of 'giving back' to community groups who have participated. Providing practical support in this way did successfully 'give back' at the community group level, i.e. general access to community group members was reciprocated by access to my administrative skills. However, this strategy did not adequately 'give back' to members who participated in group and in-depth interviews. In fact, in some instances, this strategy may have exacerbated the degree of exploitation, as individuals may have felt obliged to participate not least because of the personal friendships that had developed between myself and group members. Taking up a position of administrator played down my role as a researcher, and helped reduce the authority invested in the 'researcher' role; however, the position of administrator locked me into a different power relationship, that between 'organisers' and group members, thus investing in me an entirely different authority. This position as part of the structure of provision is more likely to have created a sense of obligation to participate, out of gratitude, than the position of supplicant researcher would have done.

This phase of access for other community groups was far less involved and reasons for this varied with each group. In the case of community group 3, I was able to establish good rapport with informants within only one group meeting. This was partly because the group numbers were small, making it easier to talk to everyone present. In addition, although members of the group took me and the research seriously, from the outset it appeared that that they did not perceive the 'researcher' role as holding more power than their own role as 'researched'. Therefore the research relationships within this context were very equal, which enabled trust to be established rapidly.

In the cases of community groups 4, 5 and 8 the unpredictable nature of group attendance meant that I had to arrive at these groups prepared to interview on the spot. I was able, however, to have some informal conversations with members of community group 4 prior to the group interview that took place. Limited time with which to establish rapport did affect the material produced (this is discussed in chapter

4). Community group 6 initially declined to take part because the group was already participating in other research at the time that I met the co-ordinator. However, the co-ordinator introduced me to group members she felt would be willing to participate in in-depth interviews. I was able to speak with these informants only briefly by phone prior to the interviews which may have affected the nature of the health and illness accounts produced, to some degree. Finally, community group 7, which ran lessons developing specific skills, did not have a group forum through which I could meet group members informally. Therefore I was only able to have a brief discussion with informants prior to in-depth interviews.

Phase 3: accessing informants for group interviews.

Developing a rapport and trust with community group members was essential to securing participation in group interviews. However, using community groups as a means of accessing informants meant that individuals who participated were not always doing so on a wholly voluntary basis. Group co-ordinators often played a role in this phase by directing me towards group members they felt would be willing to take part. Where co-ordinators used their authority to 'encourage' group members to participate, informants were not entirely willing participants. This was particularly noted in group interviews A and B. There is also a danger that co-ordinators may have directed me to, or away from, individuals who did, or did not, hold views that the co-ordinator deemed appropriate to be included in this study. Negotiating this was difficult. Where it took place, 'encouragement' to participate was often in my absence, and so the extent to which this occurred has never been clear, making it a difficult issue to address. Plus, there was a very real possibility that without some encouragement from co-ordinators group members would not have 'volunteered' to participate. Access to group members also relied on the co-ordinators of these groups to a large extent, and therefore it was important not to alienate the co-ordinator in the decision making process by disregarding their advice. It was also the case that these leaders knew which individuals would be responsive in a group setting, which is important information for setting-up group interviews. In discussions with co-ordinators then, I emphasised my need for their expertise in choosing informants who would be conversant in a group, rather than their knowledge of group member's views. Table 3.2 lists the participants of group interviews (details of those participants who also took part in in-depth interviews are listed in table 3.3). The table shows

Table 3.2. Group interviews and participants by community group.

Community Group 1		**Community Group 2**		**Community Group 3**		**Community Group 4**	**Community Group 5**	
Group Interview A (women aged 50yrs and above)		**Group Interview Bi (women aged 50 yrs and above)**		**Group Interview Ei (women aged 30-50yrs)**		**Group Interview D (men aged 50 yrs and above)**	**Group Interview F (women and men aged 18-20 yrs)**	
Annie	Emma	Ivy	Nasreen	Clare	Enid	Albert	Guy	Jill
Betty	Fiona	Lisa	Kerri	Brandy	Avril	Benjamin	John	Laura
Cathy	Helen	Melanie		Dorothy		Charles	Nick	
Diane	Geri							
Group Interview C (men aged 50 yrs and above)		**Group Interview Bii (women aged 50 yrs and above)**		**Group Interview Eii (women aged 30-50 yrs)**				
Michael	Lenny	Ivy	Teresa	Clare	Enid			
Ken	Nigel	Nasreen	Winnie	Brandy	Francis			
Owen	Paul	Rose		Dorothy				
Quentin	Robin							

clearly the variations in numbers of participants in each group, reflecting the difficulties in securing access.

Access to the groups was not fixed for the duration of the group interview, so that I was required to be responsive to informants in this respect during the discussion too. In all cases where withdrawal of access was threatened during interviews, trust and rapport were central issues. This was more likely to occur in circumstances where I had not been able to spend any length of time with participants prior to the interview. Group interview F in particular involved a continuous struggle for access. Participants made it clear after they had read through the question items that they found them to be 'boring' (see extract below):

> "Jill brought the discussion into a new aspect by declaring that the questions were 'boring' and that she wouldn't want to fill it in … there was a spoken consensus about how boring it might be, especially from Laura who wanted to know 'why do you want to know this stuff?'"
> Field notes to group interview.F. Lines 38-46.

Field-notes in this extract record Jill's comments that *"she wouldn't want to fill it in"* and in response I made the decision to change the format of the group interview so that informants were only asked to discuss the questions, rather than complete the question items. The extract from field-notes below record my reflections on this decision.

> "I realised that this group wasn't going to fill in the questions and talk. So I decided to read through question groups and discuss them [with the informants]. With hindsight this was probably the right decision: they would probably not have filled it in anyway, and there certainly would have been little discussion about the questions because they would have been too 'bored' and I would have used too much of their time already!"
> Field notes to group interview 6. Lines 24-30.

The group consensus that the questions were 'boring' does not appear to be a considered understanding of the question items themselves, but a reflection perhaps of their life stage, where rejection and contradiction are part of the resistance of adolescence. Therefore, the response of these informants to the 'questionnaire' may reflect not only the power dynamics between themselves and the researcher, but also the need to fulfil expectations of them dictated by aspects of 'youth' culture.

In group C, reluctance to participate was more evident in attempts to stall the start of the focus group discussion by informants prolonging their game of dominoes, misplacing reading glasses, and, during the group interview, by using a flippant attitude when discussing the questions. Despite the 'introduction' given by Ken and the endorsement by the co-ordinator of my research, my requests for their participation were still met with some resistance. The gender dynamics of the research relationship were also employed by informants to resist full participation. Flirting with me, men in the group were able to make the interview less serious, and may have been a means to transform the perceived authority of the researcher.

Conducting group interviews at the community group venue also opened up the possibility for withdrawal of access being precipitated by group members not actually participating in the interview. During group interview A, for example, noise from group members in an adjoining room got progressively louder, to a disruptive level. This was particularly noticeable because the day of the week chosen for the interview was selected because it was usually quiet. A lady from the group in the adjacent room then managed to break up the discussion for a short time by offering Caribbean rum around to the other members. I had noted on previous occasions that this lady was reluctant to engage in any kind of conversation with me, and her interruption appeared to demonstrate her reservations very clearly. This seemed to be confirmed further by an aside she made to me following the group interview. As I was passing her she said *"what are you going to do with all this?"* (field-notes to group interview A, line 154). Her voice was emotional and as we talked it became clear that her fears that I might be exploiting the group were strong. I took the opportunity then to respond and explain about the research focus and reasons for conducting interviews at the community group; this, and subsequent efforts to converse with her over the following weeks did eventually allay her reservations. This illustrates well the need to create a sense of trust, as an ethical consideration as well as a means to securing participation.

It is not always clear how far the actions and discourses of a group interview reflect within-group dynamics, particularly where the researcher is not party to them. These can effect the interview in positive and negative ways. One example of where within-group dynamics may have contributed positively to the discussion is in group interviews Ei and Eii. Informants belonging to this group clearly knew each other well

and were accustomed to discussing health matters with one another. This contributed to *"a free-flowing discussion"* (field-notes to group interview Ei, line 3), which involved the construction of both public and private accounts of health and illness, which was unique in this study. It should be noted though, that members of this group were all engaged in professional employment and it may be that informants were also used to expressing personal views, with the effect that they felt more willing to discuss their 'private' accounts.

Phase 4: Accessing individuals for in-depth interviews

The struggles of access experienced at phase three possibly related to the kinds of problems experienced in phase four. Where group interviews worked well, trust and rapport between researcher and researched deepened so that informants responded positively to requests to participate in the research further (i.e. in in-depth interviews). This is most clearly illustrated in table 3.3 which shows that all members of groups E and D where less tension was experienced, participated in the study further, whilst all informants (except one) in groups A and F, where access was most tenuous, declined to participate further.

The difficulties in recruiting participants of group interviews, plus the problems experienced finding informants of a particular age, led me to use other strategies to access informants. For example, Opal was 'recruited' during my contact with her in her voluntary work capacity at community group 2. Two other informants were accessed through people already interviewed: Opal introduced me to a relative, Robert, and Bruce introduced me to a friend, Jenny. However, although I was not able to spend very much time talking about the project to those informants before the interview, it seemed that the trust and rapport I had developed with Opal and Bruce meant that the research relationship was transferred to the second set of informants. It may be the case though, that these informants were particularly open to talking about their health and illness experiences, indicated by the fact that I was directed to them by their friends and family.

Table 3.3 lists the characteristics of informants who participated in in-depth interviews. These descriptions have to be limited in order to preserve anonymity of

Table 3.3. In-depth interview participants and key personal details.

	Name	*Community Group*	*Group Interview*	*Personal Details*		
				Occupation	*Marital status*	*Children*
Women 50 years & above	**Cathy**	1	A	Retired (previously worked for NHS)	Divorced	Yes
	Valerie	2	-	Retired (previously worked for NHS)	Divorced	Yes
	Kerri	2	Bi	Housewife	Divorced	Yes
	Enid	3	Ei, Eii	Health worker	Single	Yes
Women 30-50 years	**Francise**	3	Eii	Community worker	Single	Yes
	Avril	3	Ei	Community worker	Single	Yes
	Brandy	3	Ei, Eii	Administrator	Single	No
	Melanie	2	Bi	Unemployed (skilled professional)	Single	No
Women 30 years & under	**Opal**	2	-	Community worker	Single	No
	Jenny	6	-	Not known	Living with partner	Yes
Men 50 years & above	**Charles**	4	D	Retired (skilled manual work)	Married	Yes
	Benjamin	4	D	Retired (skilled manual work)	Married	Yes
	Denzil	4	-	Retired (skilled manual work)	Married	Yes
	Albert	4	D	Retired (skilled manual work)	Married	Yes
Men 30-50 years	**Theo**	8	-	Unemployed (skilled manual work)	Single	Not Known
Men 30 years & under	**Bruce**	6	-	Community worker	Single	No
	Harry	6	-	Unemployed	Single	Yes
	Graham	6	-	Unemployed	Single	No
	David	7	-	Not known	Single	No
	Robert	2	-	Househusband	Married	Yes

informants, but do convey key aspects of their social location. Among older informants previous occupations reflect the period within which they migrated to the UK. During the late 1940s – mid-1950s large-scale recruitment was taking place in the NHS (particularly for nurses and auxiliary staff) and for work in transport and building industries, to name a few. Incoming migrants were drafted into these positions (Anthias and Yuval-Davis 1992). Their racialised experiences in employment often meant that they have also experienced financial hardship. The employment profiles of younger informants are more varied, although unemployment among young African-Caribean males also reflects a growing trend.

Also of interest is the fact that in the older age group three out of four women have been married (the reasons for divorce are examined in chapter 5) and that all four men interviewed remain married. This is an interesting contrast to the less traditional arrangements among younger informants who are mostly single. Only one informant (Robert) is married whilst another (Jenny) is living with a partner. Whether informants have children or not does not seem to take such a clear generation pattern.

3.4. Recording and analysing the research material.

3.4.a. Data collection and management of material.

Analysis of the data relies on an appropriate means of recording it. I aimed to record as much of the verbal interaction in an interview as possible so that the analysis can examine the text as a construct that is wholly the interviewee's. The choice of recording interview data then, has been fairly limited to tape recording because of the ability it affords to record informant's narratives word for word, as well as the mood and tone in which narratives are discussed. Tape recorders also record silences, which can communicate an important point. Tape recorders are also useful for freeing the researcher to concentrate more fully on the discussion that is taking place, improving the quality of the discussion. For example, they enabled me to maintain eye contact with informants, which is an important consideration when establishing trust and rapport is so crucial. However, tape recorders can be problematic when informants do not feel comfortable with having their comments recorded. This was not often the case

in this research,[7] but where this did occur I used field-notes as a means of recording detail of the discussion. Field-notes were also used to record other interactions with community groups and their members, what Burgess (1984) terms as the 'substantive field notes.' These notes have been particularly useful where they record informants' responses to research, and have enabled me to 'relive' the interview more accurately during the process of analysis. Kvale notes the 'opaque screen' (1988: 99) that the transcript can form between the researcher and the original interview situation, and field-notes can act to bring the transcript into a lived context. However, it should be noted that field-notes record the researcher's impressions of interactions, and these may not be shared with those of the informant. In addition, because field-notes have been recorded through recall, they do contain an element of selectivity: what is recorded relies on the researcher's interpretation of what may be important to note. Even when attempting to record impartially, the subjective interpretations of the researcher can still be pervasive.

The field-notes were hand written on a sheet with typed headings which make it easier to record the details of the event as well as my own reflections. The taped interviews were transcribed verbatim by word processor and all informants have been given pseudonyms. I have used a system of notations to represent pauses, inaudible speech or simultaneous speech, most of which are taken from Jefferson, cited in Potter and Wetherall (1987). See appendix IV for a list of the notations.

3.4.b Data analysis.

The process of interpreting qualitative material is notoriously hidden, reflecting the difficulties in expressing how a valid interpretation of meaning is reached in a process that is often highly personal. The process used in this study relied mainly on continual reading and re-reading of research material and layering of coding that was both descriptive and analytical. In some ways the process of analysis began at the start of

[7] Recording information in writing was much more problematic for informants – see discussion in chapter 4.

the research. As Geertz suggests, "one does not start intellectually emptyhanded" (Geertz, 1973: 27, cited in Burgess *et al.*, 1988a: 321). In this case, my leaning towards a post-structuralist perspective meant that interpreting material through an understanding of power relationships was fairly inevitable. However, although this may have formed the basis of my interpretive strategy, a main premise of this study has been to allow informants own stories to 'emerge' from the data. Therefore I have used the process of reading, coding, re-reading, coding again, to develop categories of codes that reflect as closely as possible the main issues that have emerged from material.[8] This process began with the first meetings with community group members, so that my interpretations do not rely solely on interview transcripts but on the context within which I was working as a whole. Formulating initial interpretations at an early stage of research allowed me to pursue themes that were emerging in interviews, so that although interviews were unstructured I was able to pick up on themes that had been previously noted, and explore them with the informant further. In addition to this, I found it useful to keep asking myself 'would informants of this study find my interpretations credible?' This has been a useful check on how valid my interpretations might be. I took this a stage further by conducting 'feedback sessions' with informants where I have discussed the main findings of research with informants.[9] These sessions have been an important means for me to 'check' with informants whether my representations of them are credible, and for me to gain more insight into aspects of material whose meaning was not clear to me. The way that these sessions are conducted is important. Therefore feedback sessions have been an important means to both validate existing material whilst generating it at the same time. Baxter and Eyles (1996) suggest that feedback sessions should be done "in the spirit of an 'exchange of ideas'" (Baxter and Eyles, 1996: 515) to prevent the session becoming a conflict of ideas between informants and researchers.

---

[8] Although Cornwell's ideas about public/private accounts have been a useful framework for discussing research findings, this framweowrk was not used from the outset and 'impose' on the material. In fact, Cornwell's ideas were dicovered in the process of explaining the clearly different kinds of accounts that I was finding.

[9] This was also an important strategy as a means of 'giving back to informants.'

Computer assisted qualitative data analysis: NUD.IST.

During the process of analysis of transcripts, I experimented with the NUD.IST computer programme as an aid to the analysis of qualitative data. I did find this package useful in terms of developing codes and the assistance in data management that it offers. However, in general I found the programme difficult to use in the context of this research. I found that it was important to regard each interview as a whole, and that coded notation written on each transcript, alongside interpretive notes to myself, was much more workable in this instance. This meant that I was able to develop an understanding of the complex interaction of beliefs and experiences expressed by each individuals, and I was able to retain a 'feel' of the mood and context of the group or in-depth interview.

I also share the concerns expressed by Crang *et al.* (1997) about the use of computer assisted data analysis systems to 'fill the gap' that many researchers experience in deciding what they can justifiably interpret from the data. Packages do offer a sense of structure and tangiability that may 'fill the gap' but, Crang *et al.* suggest, this may mark too much order. This is a sentiment I share. In attempting to structure my analysis through NUD.IST I felt that the structured thought it demanded was impinging on my freedom to explore material backwards, forwards, side-ways and diagonally, from below and above. Instead I found myself attempting to impose categories and codes on the data rather than 'discovering' themes in the material. For my own work practice, NUD.IST would be most useful as a management system of codes once this has become firmly established. Although, by the time this stage has been reached, a coding system is already well established. As Crang *et al.* (1997) suggest, this kind of package would be more useful to qualitative researchers if it allowed them to write through the material, rather than writing it up.

3.5. Conclusions.

In this chapter I have outlined various strategies which address the moral dilemma posed in chapter 1. Taking a feminist approach to methodology enables the researcher to be explicit about power relationships, so that although these relationships of

'uneven' power may not be entirely mediated, they are at least made explicit. Being explicit, it is then possible to explore how research power relationships inform the development of health and illness accounts. These power relationships have been prioritised in my discussion of methodology, and affect the interpretation of research material discussed in later chapters. This is because of my attention to, in particular, racialised power dynamics with in research relationships. I have outlined the nature of these relationships and it is clear that there are variations in the ways these have developed between women and men and between different generation groups. These variations are reflected in informant's accounts, discussed in chapter 4.

In this chapter I have also discussed critically the use of community groups as a source of informants. There are many positive aspects of this strategy from the perspective of conducting research: community groups, once initial access is negotiated, provide key informants, a number of potential participants, and a venue that allows participants to offer access to the researcher in spaces that are familiar to them, but at the same time are not the private space of the home. However, this strategy may have provided access to a relatively select part of the African Caribbean population in East London. Therefore, findings outlined in the following chapters should not be interpreted as an indication of the African-Caribbean population in general, but read as an exploratory insight into the possible connections between gender and the experiences of health and illness. In this chapter I have set out my position as a researcher and the ways that this has informed my choices of research methods and strategies in the field. These choices have reflected the nature of the research problem and the social positions that are occupied both by myself and the informants.

4. Reservations, Morality and Gender: How Health and Illness Accounts Are Developed.

4.1. Introduction

This chapter explores the kinds of health and illness accounts produced by informants in this study. These accounts appear to be influenced by several factors, including research context and aspects of social location, such as gender, 'race,' stage of life-course and socio-economic position. In section 4.2 I reflect on the guardedness exhibited by informants in completing the 'questionnaire' during group interviews and in discussing their health and illness experiences which I have attributed largely to the social distance between the informants and myself, although other factors, such as the extent to which participants were acquainted with the researcher,[1] and the level of friendship that existed between group interviewees, are also considered as influences on how far informants wished to discuss their health and illness experiences.

Cornwell's ideas about 'public' and 'private' accounts (1984)[2] help to distinguish the kinds of accounts that are produced in different interview situations, and her work is used to in this chapter to examine informant's discussions of their health and illness. Evidence in this study suggests that accounts may be more 'public' when informants feel reserved about participating in research or disclosing personal information. In particular, public accounts were more evident during group discussions about the health 'questionnaire,' due, perhaps, to concerns about how information on paper might be used, and the presence of peers in the group discussion. Public accounts reflect several different influences, and the two more dominant influences, a medical discourse and discourses of morality, are discussed in sections 4.3 and 4.4.

[1] See Burgess (1984) about achieving different levels of familiarity with informants.
[2] See discussion in chapter 2.

Whilst public accounts were produced in all interviews, private accounts were more likely to be discussed during one-to-one in-depth interviews. Informants appeared to express 'private' health and illness accounts when they felt more comfortable with the interview context, particularly with regard to whom was listening to their accounts. Women and men both produced public accounts, but their accounts often seemed to be influenced by discourses of morality in different ways, reflecting traditional understandings of gender role expectations and notions of femininity and masculinity. Women and men often differed in the way that reservations in discussing health and illness and completing a 'questionnaire' were manifested too, although gender differences are not consistent over the life-course. In general women were more likely to *voice* their concerns, whilst men took more evasive action.

The terms 'public' and 'private' accounts, coined by Cornwell (1984), can be misleading, therefore demanding some clarification of their use in this study. Here 'public' and 'private' does not imply that informants use public accounts solely for *public* discussions, and private accounts for more *private* discussions. Neither do these terms imply that private accounts are more 'real' to the informant than public accounts and that they should, therefore, be prioritised. Although evidence does suggest that where informants feel that they might be judged by the accounts they discuss, either by health professionals or their peer group, they are also likely to select accounts that they perceive will be acceptable. Instead, informant's narratives about their health and illness experiences move continuously in and out of public and private accounts and all accounts are expressions of how particular experiences are interpreted and understood.

Section 4.6 explores the health and illness accounts developed during in-depth interviews by two informants, Melanie and Robert. These two interviews illustrate that individuals can use several different accounts, both public and private, to explain their various health and illness experiences and that these accounts are not necessarily contradictory to one another. Stainton-Roger's (1991) terms this as 'account sympatricity.' Although I have not specifically categorised the accounts of informants in this study according to Stainton-Roger's (1991) criteria (see table 2.1, chapter 2), I have made reference to these categories. I suggest in this chapter that women and men in this study often developed different types of accounts. Male

informants were more likely to use the same, often public, accounts as each other, whereas female informants discussed a wider spectrum of both public and private accounts. Therefore, throughout this chapter will be made.

4.2. Guardedness in completing health questionnaires.

Informants were often reluctant to complete the 'questionnaires' given to them in the group interview to discuss their personal ill health. This section explores the reasons given for that. For some informants this might have been part of a common response to what some might regard as intrusive questions. However, evidence from this research suggests that reasons for reservations are more complex. For example, female informants talked about how their distrust of white health professionals and of doctors' diagnosis of ill health made them hesitate to give personal information. The effect of this was to encourage the use of public accounts of ill health in the group discussion about the questions. It is difficult to ascertain whether a gender difference exists in the reasons held for reluctance to complete, as male informants did not discuss their attitudes towards the questionnaire. However, it is clear that some older male informants did have reservations (see discussion in chapter 3), and as a result male group discussions also developed public accounts. Evidence suggests that reservations may be generation specific, therefore this section discusses the different responses to the 'questionnaire' with some sensitivity to stage of life-course.

Field-notes record that for some informants reservations might be held concerning recording personal information in any research context. For example, Winnie, in a group interview of older women, states that she has refused to participate in market research in the past (extract 1, table 4.1). Comments from feedback session ii, of older women and men, give some insight into the nature of reservations held by informants who arrived in Britain during the 1950s and 1960s. In a discussion about why people might have been guarded, field-notes record that to some extent informants felt that this reflected *"part of their culture, and how they were brought up"* (see extract 2, table 4.1). What Diane explains as *"a value of not wanting people to know your business"* (see extract 3, table 1.1). However, informants also

connected this tendency to their experiences of racism in Britain. In particular, the effects of racialised access to resources provided by statutory bodies, which has resulted in informants *"having to do things for themselves"* and low expectations of what statutory bodies might provide (see extract 2, table 4.1). In the same discussion Diane suggests that there is a strong sense of pride among those who have had to rely on themselves. Therefore a value of privacy and a sense of pride in their self-determination may explain informants' reluctance to talk about their personal experiences. In addition to this, Ken, a participant of group interview C, speculated that some of the black community *"don't really trust white people"* (extract 4, table 4.1), suggesting that the reservations held are influenced by different experiences of 'race' position. This has implications for informants participating in a study conducted by a white researcher, particularly if the researcher is perceived to be associated with the same structural agencies that have disregarded them in the past i.e. the health profession. This clearly reinforces the value of efforts made in this research to develop trust and rapport prior to, and during, interviews, as discussed in the previous chapter.

Although younger women in interview group E discussed similar experiences of their racialised position in Britain, they were less reserved about their personal experiences of ill health during the group interview. This may be because their experiences have been less extreme than those of older informants. A less entrenched sense of distrust of white people seems to have enabled a better rapport to develop more quickly between myself and group members. Also significant is the understanding held by these informants that involvement in research projects that address such issues as racism have the potential of benefiting black communities in some, if small, way. As a result health accounts produced by group interview E are much less 'public' than those produced by interview groups of older informants.

Table 4.1. Reservations about discussing health problems.

1. When I asked if anyone would prefer questions face-to-face Winnie began to talk about her reaction to other researchers – particularly a market researcher asking about her spending habits, to whom she had refused to comply because again it was too personal.
Field notes to group interview Bii. Lines 46-50.

2. "I talked about a tendency towards reservations, and then asked whether this was a Caribbean thing. The impression that I got was that yes, it was part of their culture and how they were brought up, but informants seemed to feel it was more about their <u>having</u> to do things for themselves … Lady 3 was fairly emotional when she said that they got nothing from social services – that no-one told them how to access resources. She felt that they had come into the country and 'worked like shit' and were rewarded with little, compared with those that did nothing. Even when they did ask, she felt that they were often told that they weren't entitled to resources. This account was agreed with by others and later there were some specific examples…"
Field notes to feedback session ii, following group interview A. Lines 16-33.

3. "Diane noted that there was a strong sense of pride amongst those who had worked all their lives, and they didn't really want to ask for help, even for pension. This was exacerbated by a value of not wanting people to know your business."
Field notes to feedback session ii, following group interview A. Lines 66-69.

4. Ken: Well, I don't really know why. I suppose maybe a lot of our don't really trust [speaks quietly] white people.
Interviewer: Yeah.
Ken: Lets put it that way! [laughs]
Interviewer: Right, okay.
Ken: I don't know if perhaps if you were a black girl, black woman, if they would be more open to you I don't know.
Interview Ken. Page 8, lines 10-16.

There was little indication that the kinds of reservations held were different between women and men. However, female informants were more likely than male informants to express these more openly and be candid about the nature of their reservations. This might reflect the gender dynamic of the research relationship to some extent i.e. talking openly to a female researcher may have been less problematic for women than for men[3].

The guardedness of informants, discussed above, was manifested most strongly in their response to question items. Experiences of racism, and the perceived lack of support given to minority ethnic groups, not only appear to have promoted self-

[3] Women's greater propensity than men to be open about a variety of issues is noted throughout chapters 4 and 5

reliance and a sense of pride about this, but also a strong distrust about recording personal details on paper. Despite strenuous assurances by myself that the information recorded would remain confidential, strong concerns were voiced about how their personal details are used. In some cases, such as among participating members of community group 1, there was a concern that such information might be used in a discriminatory way.

Table 4.2. Concerns about diagnosis.

1. "There seems to be a fear of writing things down. Perhaps because of a more oral tradition [of communication], but perhaps it is also because of fear of repercussions which may have happened in the past? [This is best illustrated] when Annie started out by saying that she wasn't going to fill anything in."
Field notes to group interview A. Lines 38-40.

2. "One lady complained about having to tell people her ethnicity at the doctors – she interpreted it as a possible conspiracy so that she would not get good treatment/ different treatment to whites."
Field notes to the discussion prior to group interview A. Lines 49-50.

3. "[the women] mentioned how they got to understand the 'little tricks' of keeping black children from doing well in school – they spoke in allusion to a white conspiracy to keep black people down."
Field notes to preliminary discussion to group interview A. Lines 28-30.

4. "There seemed to be particular agreement over the fact that it matters who will read the answers. In fact, one or two ladies did say that they were concerned about who reads them and what they do with the answers."
Field notes to the feedback session for group interview A. Lines 40-44.

5. Francise: I, as you [Dorothy] say, if you were feeling, experiencing those feelings, you may go to a doctor. But I wouldn't, I tend not to – if it happened to be something physical, but if I had some sort of emotional thing I would be hesitating going to my doctor. Because I feel that they start recording a lot of things=
Clare: =Yeah.
Francise: And, erm, these questions they're quite powerful questions on paper. By giving this information to your doctor this can sometimes be used=
Clare: =Hmm.
Francise: You know, to support, yeah, later on you know?
Clare: Hmm.
Francise: They think, seeing them on paper that least sometimes we unconsciously say things that may have repercussion for us later on.
Group interview Eii. Lines 418-429.

For example, during a discussion among older women, prior to group interview A, field-notes record that informants alluded to a perception that collusion among

professionals, such as doctors and teachers, may exist which acts to discriminate against black people (see extracts 2 and 3, table 4.2). They suggested that such discrimination led to black people receiving less adequate health care and education than white people. Comments recorded among older women and men in field-notes to feedback session i, following group interview A, also suggests that other informants of the same community group (1) were *"concerned about who reads [the questions] and what they do with the answers,"* although they are less specific about what they expect the reader to do with the information.

These concerns are not exclusive to informants of an older age. Middle-aged women in group interview Eii also expressed their concerns about divulging health information to medical doctors, particularly regarding emotional health problems (see extract 5, table 4.2). Francise's comment, *"sometimes we unconsciously say things that may have repercussion for us later on,"* illustrates the lack of trust held by some informants regarding the actions their doctor might take in relation to patients' statements about their health. However, Francise's comments come at the end of a discussion with group member Dorothy about the difficulties in expressing 'how you feel' to doctors within the time they give you and the questions they feed you. Her comments may therefore relate to distrust in doctors' ability to make an accurate diagnosis from such questions, rather than a perception that health professionals are explicitly discriminatory. As a result of these concerns, some informants strongly expressed their reluctance to complete the question items. For example, extract 1 (table 4.2) records older informant Annie's statement, that she *"wasn't going to fill anything in,"*[4] and my own reflections that this might be connected to a concern about what repercussions completing a questionnaire might have for her. During group interview Bii with older women, Teresa became upset over question items 8 and 9 (see appendix), which refer to mental health status. Teresa was very reluctant to respond to these questions, stating that they were *"far too personal"* (Line 11, field-notes to group interview Bii). As noted above, in the same group interview Winnie is recorded to have stated her reluctance to comply with a market researcher's questions about her spending habits *"because [the questions] were too personal."*

[4] Annie did go on to complete a questionnaire.

4.3. 'Public' accounts: medical discourse

Despite informants concerns about the implications of recording personal information about health, most of the older informants did in fact complete the 'questionnaires'. Cornwell (1984) found that among her working class white informants the health profession and 'medicine' was held in high regard, and it may be that a similar respect held for 'medicine' by informants in this study explains why they completed the 'questionnaire' in the face of their own reservations. For example, some of the older female informants who participated in group interview B, who were less vocal about their reservations, were more explicit about their respect for medical authority. In some cases, the same informants actively justified the 'questionnaire' to each other. In my field-notes I record that some informants felt that it was not an intrusion to respond to questions about personal health, but that it was a *"good thing to do"* and perceived by Ivy *"as a way of finding out how healthy she was"* (see extract 1, table 4.3). They also suggested that 'worrying' (their term) about the outcomes of completing a questionnaire was *"unnecessary because 'you're just putting the truth'"* (extract 2, table 4.3). Extracts from this group suggest that this group valued an attitude that accepts medical authority and did not problematise how personal information might be used, in contrast with other participating community groups. However, the same extract also illustrates that Nasreen at least, had difficulties adhering to this collective attitude.

Table 4.3. the value of medical discourse.

1. "When Teresa exclaimed that [the questions] were 'too personal' I asked whether the other group members agreed and they did not seem to, saying that it is what doctors' want to know. There is a suggestion here then that the 'doctor' has an almost exclusive right to personal knowledge above all other professionals … Ivy especially, but Rose too felt that the questionnaire was no intrusion at all but a good thing to do. Ivy saw it as a way of finding out how healthy she was."
Field-notes to group interview Bii. Lines 92-117.

2. "When I mentioned that I had met a reluctance to answering questions, Nasreen, Ivy and Rose felt that this 'worrying' was unnecessary because 'you're just putting the truth.' It was Nasreen that said this, but she seemed to be almost re-affirming this to herself who had conveyed signs of 'worrying' earlier.
Field-notes to group interview Bii. Lines 124-129.

3. "I asked if anyone was interested in being interviewed – Jill quickly responded 'do we get paid?' I said 'no', and that concluded the question – no-one was doing anything without payment. Jill and Laura then talked about being paid £25 one time, a bottle of wine another. Jill also commented that you could make money by donating blood to a blood bank – illustrating her use of the research and medical world."
Field-notes to group interview F. Lines 59-65.

4. "Rose [said] that she would not think about her spiritual health because that was not what the doctor wanted to know. Ivy reinforced this by suggesting that the questionnaire format was better for people … who could not talk about their health without referring to the spiritual. The form, she said, forces them to respond to the options compared with a face-to-face open approach. She made a critical reference to Billy Graham's[5] response to the question 'how are you?' as 'the Lord is in me'."
Field-notes to group interview Bii. Lines 132-142.

5. "Although John said 'yes' when I asked whether it was important to have experiences of racism in a questionnaire, Jill and Laura said very loudly that it wasn't. 'No!' Jill felt that 'anyone can get abuse whatever colour, it's not necessary to know'. When I asked whether they thought institutionalised racism was significant, like in employment, housing, welfare, I heard different noises from Guy and Nick, as if it would matter, but Laura felt that was only different 'because you wouldn't even think about it. They're not going to tell you. It could be a normal reason, or it could be you're black.' Jill agreed with this, and no-one else spoke. I prompted Guy and he seemed to get quite upset, saying that asking about and working on racism was 'pathetic.'"
Field notes to group interview F. Lines 87-98.

Among the youngest informants, Jill, during group interview F, also suggested that completing a health questionnaire held a personal value for her. Field-notes record her statement that she would *"normally go anywhere to fill one out"* (field-notes to group interview F, line 104), indicating that she does not feel reticent about divulging details about her health. It is likely that Jill's enthusiasm for questionnaires is at least

[5] Billy Graham is an Evangelical spiritual leader, often appearing on television.

partly explained by the financial rewards that might result by completing one. That this is an important consideration for her is illustrated in the response *"do we get paid?"* to my request for volunteers to be interviewed in-depth (extract 3, table 4.3). However, there was also a sense that Jill at least, enjoyed the self-reflection that completing questionnaires about herself afforded, which might be similar to that expressed by Ivy in group interview Bii.

Regarding questionnaires in an unproblematic way appears to have encouraged some older female informants to prioritise a medicalised understanding of their health status. In group interview Bii, Ivy and Rose emphasise the distinction between spiritual and medical interpretations of health status, apparently placing greater value on the latter, perhaps because of it's appropriateness to the context of questionnaire completion. This is in direct contrast to informants in other group interviews who suggest that there should be *more* emphasis on the connection between spiritual and bodily health. Prioritising medical interpretations of health status in this way may reflect in part the fact that many of group interview Bii members are working or have worked as nurses or carers in a medical setting.

Similarly, informants aged 18-20 years, who participated in group interview F, had a fixed understanding of the kinds of knowledges that are required from health questionnaires. For example, when I asked informants to comment on question 11, which lists strategies people use to cope with worries, field-notes record that they questioned whether this item was relevant to understanding health. Laura stated *"these aren't like questions in a health book"* (field-notes to group interview F, line 151). Stronger feelings were expressed over question item 10 and references in the question to racism. Although there was not a clear group consensus, Jill, Laura and Guy in particular appeared angry about the implication that racism and health status might be connected. Jill stated that *"it's not necessary to know"* about racism in the context of health, whilst Guy argued that *"asking about and working on racism was 'pathetic'"* (extract 5, table 4.3).

4.4. 'Public' accounts: moral discourses

The discussion in the previous two sections illustrates that responses to health questionnaires can encourage guarded accounts of ill health where informants hold reservations, and that medicalised accounts are used where informants' value medical interpretations above others. It also appears that informants are able to 'switch' to this kind of account when it is perceived to be appropriate. When informants are asked to discuss their perceptions of the 'questionnaire' and question items within a group of peers, other concerns influencing the kinds of accounts that informants' use emerged. One of the factors that Cornwell (1984) believed influenced accounts was the concern to behave in a morally responsible manner. Cornwell suggests that her informants placed a value on an approach to life and attitude towards illness which involved living moderately, being cheerful, not complaining, working hard and taking responsible health actions to limit the effect of health problems. So that despite a propensity to view health as a product of 'natural' inequalities, Cornwell demonstrated that her informants also held individuals responsible for their own health status. There is evidence that informants in this study also value responsible health behaviours too and hold individuals responsible for their health to a large extent. However, different discourses of morality appear to be used, and two of these, discourses of religion and self-governance, are discussed below.

4.4.a. Religion.

For many older informants moral discourse may be strongly influenced by church teachings. Williams (1993) has explored the role of religion in informants' health concepts in interviews with Protestants in Aberdeen, Scotland. He found their pragmatic views about living 'healthily' were underpinned by values taught by the Protestant church, where virtuous living is not only the road to good health but also the road to salvation. Religion has an important role in the lives of female informants in this study, particularly as a resource for informants facing difficult life circumstances (see section 6.2.b, chapter 6 for a discussion of this). For those informants who were brought up in the Caribbean there seems to be a strong moral

value placed on living a Christian life and it's teachings may inform the health accounts of informants who are involved in the church. Moral values connected to religion may work in another way. This is expressed most clearly when informants emphasise their religious faith. For example, when asked whether he prays to God, older informant Benjamin makes a clear statement that *"everyday I pray"* (see extract below). However, in the same extract, he notes that he *"spend[s] about half an hour and that's it"* in prayer, indicating that it is not as significant a part of his life as he first states.

> **Benjamin:** =But not because I'm worrying about, I pray. Because everyday I pray.
> **Interviewer:** So faith is very important to you?
> **Benjamin:** I spend about half an hour and that's it. And any problem it's in the bottle [of alcohol]. Let it go in there.
> Lines 123-130.

Albert, another informant aged over 50 years, appears to express a similar attitude towards his faith. When asked whether he prays, he responds initially by talking about *his wife's* faith rather than his own (see extract below). When he talks about his own faith, he refers to it in terms of his attendance at church and the fact that he has *"got this big bible from [the church] and my name print outside the cover."*

> **Interviewer:** Do you, prayer, does that help, do you pray to God, get guidance from=
> **Albert:** Yeah. Yeah. Well she's, well I would say she's a Christian. So say you're a Christian () they got a church down in Hackney. I go there every Sunday. I didn't go Sunday, because I went out Saturday night, and when I got up Sunday morning I didn't see – she went already. I didn't know=
> **Interviewer:** =You had a bit of a lie in then! [laughs]
> **Albert:** [laughs] I go to church and I got my bible. She was, joined this church, I think [date] and I got this big bible from them and my name print outside the cover.
> Lines 400-411.

The attitudes expressed by these two informants suggest that whilst religion might have a perfunctory role in their lives, they feel compelled to state that they do have faith, and it might be that there is a moral value to this. This is not gender specific. The concern to be characterised as religious is illustrated during a discussion among older women in group interview A about a question item that required informants to list ways of coping with worries (see question 11, appendix I). Although Annie originally responds to the question by ticking three different ways of coping, the

discussion between Cathy and Emma, which was not directed at Annie, persuades her that she should change her response: *"only one answer that I'm () only prayer ... cause that's all I believe in"* (see extract below).

> **Cathy:** You know, just answer the prayer and meditate because most of us here=
> **Emma:** =Eeeh?
> **Cathy:** Prayer when we have our problems, we just get down there and talk to God about it. And the friend comes afterwards only to give you a bit more, ease. Make you feel comfortable in yourself=
> **Emma:** =Yeah, we don't go to counsellor.
> **Cathy:** No, no, no, no, no, no, no=
> **Emma:** =We sort it for ourselves.
> **Cathy:** We sort it for ourselves. But prayer first.
> **Annie:** Only one answer that I'm () only prayer=
> **Cathy:** =We do prayer=
> **Annie:** =Cause that's all I believe in.
> **Emma:** [Sniggers]
> **Cathy:** Prayer and meditate. What you prayer about will come to pass.
> **Interviewer:** Right okay.
> **Cathy:** Because we are very very religious and we live by the bible as much as we can.
> Group interview A. Lines 575-590.

The over-emphasis of older informant Valerie, that *"prayer is wonderful"* (see extract below) may also be interpreted as an expression of a public account.

> **Interviewer:** Is religion, or should I say prayer important, in the times that you were ill, did prayer help you get through those times as well?
> **Valerie:** Oh yes. Prayer is, prayer is just wonderful. Prayer is wonderful. Wonderful, wonderful. Prayer is wonderful.
> Lines 383-386.

As a result it is useful to make the following distinction that religious teachings can create different kinds of public accounts, whilst religious faith and beliefs influence private accounts. This is explored further through the accounts of Melanie, in section 4.6.a.

4.4.b. Self-governance

Younger informants use a morality discourse that is underpinned by values of self-governance, promoted in particular by Health Promotion, as outlined in section 2.4.c, chapter 2. Self-governance emphasises an individual's responsibility for monitoring and controlling life circumstances in order to promote the health of the 'self,' and the

well-being of the nation. In particular, individuals are expected to lead 'healthy' lifestyles. This differs then, to a moral discourse underpinned by religious teachings of 'good' behaviour and the pathway to salvation. However, in practice, the two discourses are often mixed considerably.

Younger informants, particularly Opal, Robert and Bruce, discuss their prevention strategies at length and illustrate that these have become incorporated into their approach to life in general. Bruce's accounts mix values of masculinity, his martial arts teachings and ideas of self-governance (see section 6.2.c, chapter 6). The accounts of Opal and Robert illustrate a mix of religious beliefs and self-governance (see section 6.2.d, chapter 6 for a discussion of Opal's health and illness accounts and 4.6.b, this chapter, for a discussion of Robert's accounts) so that there is almost a doubling of moral responsibility for these informants to remain healthy. In contrast, the discussions of older women and men over 50 years did not reflect an influence of self-governance to the same extent. Where 'lifestyle' was discussed, it was usually in relation to advice about diet and exercise from a health professional about a specific ailment. This is particularly noted in the discussions of those with diabetes or hypertension.[6] These adjustments to lifestyle do not reflect a wider change in approach to life that is noted among younger informants.

Concern about moral behaviour is evident in the discourse amongst some informants in this study, who displace personal blame for ill health. The extract below illustrates the kind of judgements that might be made by older informants towards others who are seen to be malingering, or not taking responsibility for their actions. Helen suggests that people are to blame when they have little to do with their time and when they fail to act appropriately:

---

[6] It is interesting to note that women were more likely to discuss dietary adjustments, whilst men emphasised adjustments to exercise levels. These findings are similar to those of Saltonstall (1993) who suggests that it may reflect gendered notions of the body and how to control it.

> Helen: … all the people who don't have as much to do, as soon as they've got a headache they're down, you know, because they haven't got enough to do and they're not taking what they want to do on board.
> Group interview A. Lines 151-153.

Concern about these kinds of judgements has influenced the development of public accounts of health and illness, both in group and in-depth interviews. In some cases blame for ill-health was displaced by discussing illness onset as something outside of an individual's control, such as illness through an accident, illness as an attack or through a predisposition to illness. For example, older informant Lenny (see extract 1, table 4.4), who takes great pains throughout group interview C to demonstrate his physical and mental health, clearly emphasises that the only illness he is prepared to talk about was incurred at work. He blames this on his employers, who encouraged him to lift something he feels he was not able to do. Another legitimisation of illness is illness that is perceived to be the result of an 'attack', whether from an unseen force, or from a part of the body itself. The comments of older informant Owen in extract 2 (table 4.4) illustrates how the body can be talked about as an entity with a will separate to that of the informant. Talking about the onset of illness in this way acts to displace blame from the person. Similarly, a predisposition for ill-health can be seen as outside of an individual's control, perhaps as something inherited or as part of a person's individual constitution. In extract 3 (table 4.4) older informant Annie is talking about the way her son makes her rest when she is ill. As part of this conversation she explains that his sensitivity may be due to his own predisposition to be 'sickly.' Although this might be construed as the fault of an individual, the fact that Annie's discussion juxtaposes her son's predisposition against the way that he has cared for her when she was ill vindicates him of blame for not acting responsibly.[7]

[7] It is interesting to note that Annie is concerned to portray her son in a favourable way as well as herself. This suggests that her son's behaviour may reflect on her as a parent.

Table 4.4. Displacing blame.

1. Lenny: … I had an accident about 1986 at work=
Interviewer: =Right.
Lenny: In the spine of the back. I picked something what I shouldn't have done but they told me to do it. And when I pushed this thing, I felt me spine in the back. They went and put it in the book, the accident book=
Interviewer: =Right.
Lenny: But now it's beginning to affect me now.
Group interview C. Lines 308-314

2. Owen: Bad health. I have a bad heart you see.
Interviewer: It's your heart.
Owen: Yes …
Interviewer: Right. [silence] And when you think about your health, you don't think of your emotions, anything like that? Just=
Owen: =Well the heart sabotage the whole body, innit?
Group interview C. Lines 56-63.

3. Annie: I know. Cause I've got a son and I'm always on the go, and he looks at me and he says 'Mam you are not well – get upstairs to bed!
All: [laughter]
Cathy: That's the Lord! [laughter and chatter] …
Annie: And he organises! I don't know if it because he had been through so much ill-health, because he was a sickly child from day one right up…
Group interview A. Lines 174-175.

Lastly, to reinforce the fact that the illness experience was real, and not the fault of the individual, informants sometimes referred to the diagnosis and advice they had been given by doctors and other health professionals to legitimise their health problem. Informants also emphasised the health actions they were taking to address the problem to allay any suggestion that they were acting in a malingering way.

Cornwell (1984) suggests that moral behaviour may be tied up with moral attitudes to 'work' and 'function,' which, in turn, are tied up with health and illness accounts. There also appears to be a class dimension to the use of morality discourses with a tendency for moral discourses to be used in health and illness accounts predominantly by 'working class' informants. This is clearly noted by Cornwell (1984), and there is also evidence from this study that this may be the case, particularly amongst older informants as informants in this study whose accounts are influenced by moral discourses either are, or were, working in unskilled, or semi-skilled professions. It is not clear whether the age dimension reflects the ability for younger African-Caribbeans to achieve higher status employment and a more

middle-class lifestyle[8], or that there has been a change over the generations in the way that religious teachings have been incorporated into daily life, and it is likely to be a mix of the two.

4.5. Gender differences in health an illness accounts: function and strength.

Women's and men's accounts reflected other discourses specific to their gender roles. Female informants, particularly older women, were concerned to emphasise their stoicism, whilst male informants were more concerned to emphasise their physical and mental robustness. This appears to reflect the traditional sexual division of labour that defines 'function' and 'work,' although this is not consistent amongst women and men younger than 50 years of age. This may partly reflect the changing nature of access to status in employment for younger informants, plus the changing nature of gender expectations for women and men.

4.5.a. Accounts of female informants

For older women there was a certain sense of pride in 'carrying on' in their daily lives despite the health problems they may experience. Extracts from group interview A, of older female informants, illustrate that there was a collective value given to 'keeping going' despite health problems. Diane's comment that *"you have to, in't it?"* (extract 1, table 4.5) indicates that 'keeping going' may be partly a response to practical restraints on taking up the sick role, however temporarily, for everyday illnesses. The moral value of 'keeping going' may also reflect a sense of pride borne out of coping from day-to-day with financial, material and social disadvantages, discussed in section 4.2 above. Although these informants did not specify their income levels, it was clear that older female informants had experienced financial hardships throughout their working lives in Britain. This is consistent with other work that documents black women in Britain working outside of the home, as well as in their family capacity, in response to the low incomes typically paid to black

[8] Better access to high status employment for younger African-Caribbean women and men reflects changing racialised boundaries.

Table 4.5. Women's roles and women's stoicism.

1. Emma: When I've a headache I still do work ...
Diane: You have to, in't it?
Emma: Yeah! [ ] Too right you know, you carry on.
Transcript to group interview A. Lines 155-158

2. "Informants, particularly Dorothy, talked about the expectations of them, as women, in the home, which started from childhood – meals, laundry, financing [their children's] school, home-keeping, etc. They noted that these were so engrained that women judged other women who 'failed' in these roles, and there is a kind of competition to achieve the status of being a perfect 'woman.'"
Feedback session ii following group interview E. Lines 116-121.

3. Helen: If the woman gets a cold, she does all her chores, she looks after the children, she looks after the home and she's on her feet. If a man gets a cold he's in bed and he's [agreement and laughter] and closes the window=
Cathy: He's the worst baby out.
Transcript to group interview A. Lines 112-115.

workers (for example Anthias and Yuval-Davis, 1992). Middle-aged informants in feedback session ii, with participants of group interview E, explained that concern to give the impression of 'keeping going' was due to "*a kind of competition to achieve the status of being a perfect 'woman'*" (see extract 2, table 4.5) which centres on women's roles in the home and family environment. This is also illustrated in comments by older informants Helen and Cathy (extract 3, table 4.5). Their discussion illustrates the connections between women's gender roles, the value placed on stoic behaviour and health. In this extract informants claim women's ownership of stoicism, depicting men, in contrast, as 'giving in' to minor ailments such as a cold. Extract 3 also depicts women as more successful than men, both functionally (i.e. in completing domestic and care tasks) and morally (i.e. not 'giving in'). Their 'success' reinforces the connections between women and the home and family, and appears to exclude men from this domain.

Paradoxically, despite the value of appearing stoical, women in this study were mostly open about their own health problems, and discussing health problems openly was necessary in order to illustrate that they had acted in a stoic manner. However, where there might be a suggestion that illness was a result of *not coping*, the experience was discussed with care. Often ill health was put into a past context (see extract below) and contrasted with a greater ability to cope in the present.

> "Most of the stories were about the '60s and '70s – early arrival years. They spoke of being hardened to prejudice now and therefore it doesn't affect their health. They felt that it did before – crying from sheer loneliness and despair and not being able to go/write home because of the shame."
> Field notes to discussion prior to group interview A. Lines 31-34.

Informants were also likely to discuss instances of ill health, precipitated by emotional strain, alongside actions that emphasised individuals ability to cope with situations (see especially section 6.2.b, chapter 6). These strategies were effective in giving the impression that, despite health problems, women could cope.

In contrast, although some male informants did acknowledge that 'worries' could be created by difficult life circumstances, all either stated that they had no personal experience of worries, or evaded the topic. This was noted in the accounts of all males except Harry (the reasons for this exception are explored in section 5.2, chapter 5). Therefore, in contrast to women, men preferred to respond positively to question items, and to appear cheerful about their life circumstances, rather than stoical. This was particularly the case when discussing mental health problems. The extract below is an example of this, illustrating how, with the use of humour, Quentin distances himself from the experience of worry and effectively curtails the discussion about worries:

> **Quentin:** But if you don't worry, like me now, I just take this [] attitude. Because I'm old, I won't be better! [laughs]
> [everyone laughs]
> **Interviewer:** Right. So is that – are there any other worries that might trigger=
> **Quentin:** Erm, I couldn't say – yes. Nah, I just take life as it comes.
> Transcript to group interview C. Lines 352-356.

It has been argued that women's openness about health experiences compared with men may partly reflect traditional gender work roles. This suggests that the expectations of women to occupy the care role brings them into closer contact with health practitioners and health messages through reading material, which may encourage a greater openness about health problems compared with men of this age group. Although this is substantiated, women's 'socialisation' to be more open does not adequately explain the consistency of gender differences, particularly when the older male informants attend community groups that have regular health visitors

whom they consult, and conduct open discussion sessions about male health problems. It seems more possible that gender role expectations and ideas of either femininity or masculinity combine to produce health and illness accounts that are gender differentiated. The ability to fulfil gender expectations may also be part of a process of validation for women and men who have experience of low status in employment and in their racialised social position. Validating themselves in this way may mediate these experiences, and this is discussed at length in chapter 6. Where role expectations of women and men, and ideas of what is feminine and masculine, are more traditional, the difference between women's and men's accounts will be more marked. Therefore, gender differences may be more marked among older informants who are more likely to have traditional views of women and men. Evidence in this study supports this argument.

4.5.b. Accounts of male informants

The desire to appear physically and mentally robust may reflect the necessity of fitness to function in the manual work that men of this generation (and 'race' status) have been engaged in. However, older men in this study did not problematise or question the expectations of them in the way that female informants did, so it is not possible to make definitive statements about what expectations of men might be. It may be though that masculinity is expressed through characterising oneself as physically robust, thus producing a discourse that emphasises the healthy body.

Older men's expressions of cheerfulness and having a positive attitude gives the appearance that they are in good health, and suggests that they are coping with life. For example, Lenny's account of his health state provides a clear example of how some of the older men expressed their ability to function well physically and emotionally. In response to the 'questionnaire'[9] Lenny is often quick to answer positively to the questions he perceives as morally desirable, yet emphatic about not experiencing problems that may be less morally desirable (Extract 1 and 2, table 4.6).

[9] The co-ordinator for the community group was assisting Lenny to complete the questionnaire, by reading the questions out to him, because he did not have his glasses with him. This could have affected his reaction to the questionnaire.

The need to be seen as able to cope appears to relate to functioning in their working lives. In this respect, retirement has challenged the identity of some older male informants. For example, in a discussion about question items concerning daily activities and work, there was a concern among retired men in group interview D to justify their unemployment, by emphasising their status as retired, and that they remained active (extract 3, table 4.6).

Table 4.6. Discourses of masculinity.

1. Diane: Did you feel full of life 'All of the time?' [q8]
Lenny: Oh yes, yes [answers quickly and defensively]
Diane: [ ] 'some of the time'?
Lenny: All the time.
Diane: All the time. 'Have you been a nervous person?' 'All the time', 'most of the time' 'a good bit of the time' 'some of the time' 'none of the time' … 'Have you felt calm and peaceful'?
Lenny: Yeah man!
Group interview C. Lines 92-100.

2. Diane: Do you feel calm and peaceful 'all of the time'=
Lenny: Yeah, yeah=
Diane: =Most of the time.
Lenny: Yeah. Most of the time.
Diane: 'Do you have a lot of energy?'
Lenny: Yeah, most of the time, most of the time.
Diane: Most of the time. 'Have you felt downhearted and low?'
Lenny: Nah [quick to answer, awkward response]
Diane: 'None of the time' 'a little of the time' 'some of the time'? None. Never downhearted. 'Do you feel worn out?'
Lenny: No.
Group interview C. Lines 114-124.

3. "Albert was quick to say activities were unhindered, particularly by emotional problems. They also persistently understood 'work' as waged employment which they weren't engaged in. They used their status as 'retired' as a justification of not working – as if they needed to justify their unemployment in some way: retirement was a sufficient reason for them, compared perhaps with the inability to get work? Albert said he did help around the house a bit."
Field notes to group interview D. Lines 32-38.

The differences in the health beliefs of women and men in this study seem to reflect the nature of the moral discourses that have been illustrated above. Men were more likely to discuss 'body as machine' accounts (Stainton-Rogers, 1991) (see table 2.1 in chapter 2 for definition) whilst women, who talked more openly about the challenges to their health, were more likely to discuss accounts which reflected an

understanding of health that incorporated spiritual and emotional aspects to health status, such as 'body under siege,' 'will power' and 'God's power' accounts. These accounts reflect perceptions of the body as vulnerable to many physical and emotional stress factors, and which perceived self-empowerment or faith in God as healing forces. The 'body as machine' account reflects understandings of illness as located purely within the body, and this is compatible with the concern exhibited by men to characterise their health in terms of their physical condition, rather than their mental and emotional state. Women do use the 'body as machine' account too, but mainly at the outset of an interview, when informants are more likely to present public accounts of their experiences. The 'body as machine' account fits well with medical understandings of illness and may therefore be used as part of a public, medicalised discourse. Older male informants sustained this account throughout the interviews they took part in, including in-depth interviews, in contrast to women and some younger men who moved between different health and illness accounts more easily.

4.6. Exploring account 'sympatricity.'

In the sections above I have examined the kinds of health and illness accounts used by informants. These accounts are not used singularly by informants. Instead, different accounts are used as a way of making sense of how illness onset occurred. Stainton-Roger's (1991) refers to this as 'account sympatricity.' Informants often reflected on their life circumstances or the illness experiences of themselves and others to produce an explanation that fitted and made sense, and enabled them to justify subsequent behaviours. This meant that some discussions initially appeared contradictory: explaining the onset of illness in general, outside of individuals' own circumstances, often contrasted with accounts where personal circumstances were considered. Therefore, those who have experienced particular illness problems have developed understandings that help them explain what has happened to them and guides them towards action which they are able to take. Below I will explore this process through the accounts of Melanie and Robert.

4.6.a. Melanie's accounts

Melanie's discussion suggests that she uses different accounts to explain her illness experiences, and that she selects treatment according to what she understands the causal factors to be and what she feels is the most logical and appropriate response. As a result response to demylineation has been to use allopathic treatment and prayer; response to emotional strain has been to express her feelings verbally to friends and family.

The main experience that Melanie discussed during her interview was the illness demylineation. The importance of medical explanation was illustrated in the fact that Melanie describes the illness firstly through a bio-medical perspective: *"you've got nerves in your head, and the nerves have got a protective sheaf, called sheets of mylin protecting them. But they noticed that the sheafs in my head, the nerves in my head a lot of them were exposed, like the sheafs of mylin had been worn out"* (extract 1, table 4.7). Explaining the illness in this way was accompanied by references to the allopathic treatment and medical advice that she sought, suggesting that she perceived the treatment to be appropriate to the nature of the illness. This initial explanation may be partly 'public' in nature: by discussing her illness in this way Melanie established that she acted responsibly and appropriately when the illness started, and she was able to show that she could understand what was happening to her. Most importantly perhaps, this account allowed her to talk about her illness without being seen to be at fault, a concern that other informant's accounts also demonstrate (see section 4.4). Melanie's own concern with this is illustrated as she talks about her inability to stop herself falling and tripping: *"you know you can't stop it, you know. Next thing I was <u>down</u>"* (extract 2, table 4.7; see also extract 3). Although she talks about this to illustrate the nature of the illness, it may also be a means to convey that she was not able to help herself: *"but if I wasn't suffering from that I probably would have prevented it."*

Table 4.7. Melanie's medicalised account of demylineation.

1. Melanie: De – yes. And that is – well, how I first noticed I woke up in the morning and I was numb. I felt, I felt there was not much life in my hands and my feet, you know?
Interviewer: Right.
Melanie: And I kept punching myself and I couldn't feel, you know?
Interviewer: Right.
Melanie: And then I spent about a week at the nearest hospital and they gave me a brain scan, and the brain showed that the nerves in my head, you've got nerves in your head, and the nerves have got a protective sheaf, called sheets of mylin protecting them. But they noticed that the sheafs in my head, the nerves in my head a lot of them were exposed, like the sheafs of mylin had been worn out. So anyway, I've recovered now, but only thing is my hands, that feeling numbness still remains in my hands=
Lines 14-26.

2. Melanie: Because when that happened to me I lost my you know, balance, and two days ago I was at home I felt I was falling, but then you just can't=
Interviewer: =Mmm.
Melanie: You know you can't stop it, you know. Next thing I was down. But if I wasn't suffering from that I probably would have prevented it.
Lines 38-42.

3. Melanie: So I just hope and pray because of – I tell you last, I fell down three, was in the bedroom, I felt I was going and the next thing I COULDN'T STOP IT.
Lines 88-89.

Later in the interview Melanie begins to develop this account further by introducing a new element which incorporates her circumstances at the time of onset into her understanding of her illness, becoming what Cornwell (1984) might term a private account. The bio-medical account is still valid. However, as Melanie began to feel more comfortable with the interview and, perhaps, satisfied that she has vindicated herself of blame by the nature of her incapacity, and validated her illness through the use of doctors' words, Melanie is able to discuss her understanding of her illness more widely, drawing on other kinds of accounts. She explains her perception that her role as carer, and specifically the demands that this made of her, may be part of the cause of her illness: *"I always had to be on the alert, on the ball. So I believe all that, maybe ... it was wearing me out, you know?"* (extract 1, table 4.8).

Table 4.8. Care roles precipitate ill health

1. Interviewer: Hm. [pause] Do you have any theories, or explanations yourself why=
Melanie: Well. My Dad had been ill for, for a number of years I had been looking exclusively after my dad. And all the worries, because my dad he, you know, I'd be up in – maybe he would have an attack late at night, early in the morning, and I was always on my, on the go … So I always had to be on the alert, on the ball. So I believe all that, maybe, you know, I might have looked strong on the outside, but it was wearing me out, you know?
Lines 101-118.

2. Melanie: I think it was the whole thing, the whole situation. Because I more-or-less looked after him, do you – even when he was in the hospital the nurses always knew I was there, you know? And I would do it, practically do the nurses' job … When the doctors make their round, checking the medication, wanting to know why, what not, you know what I mean? I was there. Took a very active role in looking after him, you know?
Lines 247-256.

Extract 2 illustrates again the efforts that Melanie put into caring for her father. In addition, it also illustrates the influence of a public discourse in her account, which reflects the gendered moral values of acting stoically and caring effectively for family members *"I would do it, practically do the nurses' job ... wanting to know why, what not, you know what I mean? I was there. Took a very active role in looking after him, you know?"* (extract 2, table 4.8).

Although she alludes to physical exhaustion as a possible cause, the treatment that Melanie discusses at first is allopathic medicine suggesting that she perceives the illness to be a bodily dysfunction. This corresponds with the initial medical account of her illness as being physiological. Melanie was asked whether other treatments had been used, particularly Caribbean herb remedies, which other informants have used when suffering physical ailments. Melanie talked at length about her use of herbal remedies in the Caribbean, but explained that she had no conviction that it would work in the case of demylineation. Although she had tried some remedies, she states that *"I knew it wouldn't do anything good because my brain scan showed that the fault was in the brain, you understand"* (interview transcript, lines 696-697). This illustrates the way that informants select accounts that are appropriate the illness context they are discussing. The biomedical knowledge that Melanie has received from consultants and the tests which they have carried out has been used by her to determine which course of treatment would be more effective.

Further into the interview, Melanie discusses another strategy for dealing with her condition, the use of prayer. This was only discussed when the subject of religious faith was introduced to the discussion by the interviewer. This does not suggest that prayer was not important to Melanie. It may reflect that Melanie had taken it for granted that the interviewer would know of the importance of prayer to Melanie.[10] It may also have been due to wariness about discussing this strategy which falls outside accepted orthodox treatment in Britain, thus reflecting the authority medical knowledge holds. When Melanie is asked about whether her faith in God played a role in her experience of demylineation, although she does not talk about it at length, it was clear at the time that this has been an important means to cope with her fears for the future. Her prayers showed a belief in pre-determination and that she *"just left it all in God's hands"* (see extract below) in order, as she went on to say, to stop herself worrying, which she felt would only exacerbate the situation.

> **Interviewer:** Just going back to the erm, belief in God, did that help? How did that help you when you actually had that illness before … did that play a role then? Did you find it helpful?
> **Melanie:** Yes. I pray about it and then Ivy and Nasreen, and she and them came for me and they prayed for me and they prayed for my dad, you know? And then, just pray to God and say 'God, well, you have my future in your hands, you know what you have in store,' so I just left it all in God's hands, you know?
> Lines 639-645.

The prayer provided by the two preachers is perceived within the community group which Melanie (and the two preachers) belongs as a healing process in itself. Faith in the healing power of prayer is strong and used regularly within the community group, and is also mentioned by another informant Valerie who belongs to the same community group. Although this contrasts with the allopathic treatment which Melanie described earlier in the interview these accounts co-exist, and are equally relevant to the informant.

A third account that was introduced when Melanie was asked why she thought her symptoms were getting worse in the last few weeks before the interview. She talked about a recent failed relationship which had caused her considerable emotional distress, particularly as she felt that the man had been using her; and about her lack

---

[10] The interviewer and informant had met and had informal conversation at the Christian community group to which Melanie belongs.

of success in securing employment in her profession. The emotional strain that these circumstances had caused was obviously significant to her, particularly the failed relationship. In this discussion she suggests that not being able to express her feelings by crying may have meant that her feelings became expressed in the form of illness symptoms of demylineation (see extract 1, table 4.9).

However, in relation to the same issue, that of her failed relationship, Melanie refers to 'talk' as a successful means of *"letting things out"* (extract 2, table 4.9). In fact she states that if she did not use this means to express her emotions *"I will go MAD. I will go off my rockers!"* (extract 3, table 4.9). It is not clear whether she perceives 'talk' as a strategy that 'lets out' a different kind or degree of emotional distress to crying.

Table 4.9. Expressing emotions as cause and treatment.

1. Melanie: Even when my Dad die, I couldn't cry because I had to be strong, because him with the illness you know, sometimes with that illness sometimes he would get depressed and so – so I was the one you know, to say 'look you going to get better', you know … and 'pick yourself up'. So I sort of developed that outer thing because I don't know, I was telling you about that failed romance of mine … Because I had friends telling me 'look cry, cry, let it out'.
Interviewer: And you didn't cry then?
Melanie: I couldn't cry. I cannot, I couldn't cry. I was thinking about it, you know you feel sad, you know, and you want to have a good cry but I notice that I just cannot cry. You might find my tears trickling down you know, you touch my eyes they might be wet, but I cannot cry. In the way I used to cry. I cannot cry.
Interviewer: So you think that instead of crying and letting it come out like that it came out=
Melanie: =In that sort of illness it came out. Yes.
Lines 126-143.

2. Melanie: But I was that upset over that young man it just went to my head. From the same day, the same night I found he was no good, I spoke and I spoke and I spoke … and I've been talking about it ever since.
Interviewer: Right.
Melanie: So that's my way of letting things out.
Lines 166-170.

3. Melanie: … Cos only my aunty was telling me 'shh! Shh! Don't tell people' and so on. These things, keep to yourself, I tell her I can't. Cos if I keep it to myself I will go MAD. I will go off my rockers!
Lines 180-182.

Although these appear contradictory to the reader, it is likely that at the time that Melanie gave these accounts there were reasons for there distinction. However, this does illustrate that informant's accounts of their health and illness are very difficult to fit into pre-structured categories.

4.6.b. Robert's accounts

In contrast to Melanie, Robert's accounts of health and illness have been developed around the experience of *other people's* ill health. In particular, he makes reference to the premature deaths among close family members, and the frail health of another close relative. Experiencing these sudden deaths alongside the protracted health problems of another has caused Robert to search for adequate explanations. His Christian beliefs and ideas around minimising 'risk' through self-governance are crucial influences to his accounts, and provide a 'formula' with which he appears to live his life. Perhaps because these accounts are developed around the fixed experience of death, Robert's accounts often appear fixed too, and there is a level of consistency that was not present in most other informant's discussions. This may also reflect the fact that self-governance can form a public account too, although field-notes record that Robert did not express any reservations or distrust during the interview.

Central to his account is the idea that 'risk' to health is minimised through 'pacing' oneself i.e. making one's way towards goals in one's own time and within one's own mental and physical boundaries. He states that *"'I know where I've got to get to, I acknowledge the fact that this is my final goal, but I'm also acknowledging the fact that this is where I am now and I've got to master stage one first'"* (extract 1, table 4.10). Robert has developed this rule-for-life in the process of making sense of his mother's sudden death and his father's poor health state. He states that his father *"paced himself and when illnesses came he took them in his stride. He's done a lot of meditation, prayer, and basically he released his spirit to handle the strain that was put on the body"* (extract 2, table 4.10). In contrast, he notes that *"my <u>mum</u> on the other hand, because illness never came near her, when the illness <u>did</u> she really didn't know how to cope with it. And on top of everything else she was a workaholic ... So she never really paced herself"* (extract 2, table 4.10). Within this framework

the connections between 'pacing' and risk minimisation are then, made clear for Robert.

Consistent with this rule-for-life, Robert develops an account of ill health that holds the individual almost entirely responsible for their health problem. Robert explains that he does not understand ill health to be accidental, but that it occurs because *"somewhere along the line we left ourself open to that illness"* (extract 3, table 4.10).

Table 4.10. 'Pacing' as risk minimisation.

1. Robert: So it's a case of taking your own race and saying 'I know where I've got to get to, I acknowledge the fact that this is my final goal, but I'm also acknowledging the fact that this is where I am now and I've got to master stage one first.' When I've mastered stage one, however long it takes then I'll move onto stage two.
Lines 420-423.

2. Robert: ... people might look at my dad and say there's not much left of him. Because of the different illnesses you know ... But one thing I take account of is that he did actually learn to take care of his body. In many ways he kind of paced himself and when illnesses came he took them in his stride. He's done a lot of meditation, prayer, and basically he released his spirit to handle the strain that was put on the body. Whereas my mum on the other hand, because illness never came near her, when the illness did she really didn't know how to cope with it. And on top of everything else she was a workaholic. She had about 3-4 different jobs on the go and then on top of that she would still come home and then there was the house stuff that she would also be taking care of. So she never really paced herself.
Lines 258-272.

3. Robert: ... I normally feel that an illness has come because I feel that I've neglected something or I've overdone something previously, or in the past. I don't really believe that there is just an illness that just comes on you. Just for the sake that hey, it just wanted to come. I believe that somewhere along the line we left ourself open to that illness.
Lines 436-440.

4. Robert: ... the acknowledgement that I'm the child of God and then realising what that meant. That I'm a spirit that the Lord has placed within an earthly vessel to allow me to do more of the work that He requires me to do. And so I'm learning that it means I have to respect my body and take time with it. And know it's capabilities.
Lines 294-300.

Understanding that a person has entire control over their health reflects the self-governance discourse, although it is not clear whether this is part of a public account. However, it is feasible to suggest that, in line with other informants, if Robert had formulated his account around ill health that he was experiencing at the time of the

interview, then he may have developed a wider range of accounts to explain it's onset.

Robert's account is influenced by another discourse that reflects his religious beliefs. Robert's statement, *"I'm a spirit that the Lord has placed within an earthly vessel ... and so I'm learning that it means I have to respect my body and take time with it"* (extract 4, table 4.10) appears to compliment and justify his concept about 'pacing,' so that he is 'pacing' himself for a religious purpose.

Although Robert develops health and illness accounts that move beyond the 'body as machine' account that is typical of male informants in this study, the fact that he only talks abstractly about his understandings of health and illness, suggests that discourses of masculinity may also influence his account to some degree. The only personal illness experience that Robert mentions was portrayed as accidental and in the past (a back injury sustained at work when he was younger) and was not discussed at length or in any detail. By distancing the listener from present-day personal experiences Robert gives the impression that he is both mentally and physically healthy and that he is coping with his life circumstances. These are traits many men in this study were concerned to portray.

4.7. Conclusions.

Evidence presented in this chapter illustrates that aspects of social position can inform narratives around health and illness. Gender differences in particular have been discussed at length, and findings show that both female and male informants express aspects of their gender identity through their discussions of ill health. For example, women expressed their strength by emphasising their stoic attitude to the ill health they have experienced, whilst men expressed their physical and mental robustness by presenting themselves as healthy. Findings also showed that women were more likely to make a connection between emotional distress, or 'worrying,' and their health problems than men, which may reflect the different gender social roles that women and men are expected to perform (this is explored at length in chapter 5).

Gender differences in accounts of health and illness are not consistent across all informants, however. Differences are most pronounced among older female and male informants, and I have suggested in this chapter that this may be explained by the adherence to more traditional understandings of gender roles and expectations among this age group. How far socio-economic status might influence these patterns of health and illness discourse is not fully explored. Economic and material disadvantage proved to be very difficult discussion points during the interviews so that material relating to socio-economic status is limited throughout this study. However, it is known that informants, with the exception of members of community group 3, had experienced or were experiencing some level of economic disadvantage, leading me to speculate in section 4.5 that understandings of gender roles and expectations have been influenced by experiences of hardship and the need to 'get by'. This may have, in turn, influenced the kinds of health and illness accounts that informants discussed. Lastly, at the beginning of the chapter, the influence of 'race' position on health and illness accounts was discussed. Evidence suggests that, for older informants, insecurities that were based on prior experiences of racism affected responses to the 'questionnaire', making individuals more guarded about recording personal information. Comments by some informants also suggested that experiences of racism may also have encouraged a guardedness among some about *speaking* to a white health researcher about personal information. It is difficult to show clear evidence that guardedness affected interview discourse itself, but it has been assumed in this study that this may have been the case.

In this chapter the dynamics of the relationship between researcher and researched has been prioritised to a large extent, reflecting the influence of a social constructionist approach to interview material. This was also a priority for Cornwell (1984) whose work has been referenced to a large degree throughout this chapter. Her understanding of the discussion and development of public and private accounts led her to suggest that developing rapport with informants allows the researcher to capture a wider array of informants accounts i.e. both public and private accounts. The approach taken in this study has also emphasised the development of rapport with informants (albeit for different reasons to Cornwell – see section 3.2.a, chapter 3) but the outcome has not necessarily been the emergence of a wider range of health and illness accounts. Male informants in particular did not seem to respond to

the development of a relationship very sensitively, and many of their accounts remained fixed in both group and in-depth interviews. Female informant's discussions, in contrast, *were* likely to become more dynamic as interviews progressed. Again, this gender difference appears to be more pronounced among older female and male informants, suggesting perhaps that the adherence to a more traditional masculine identity may have influenced the static nature of these men's accounts. If this is the case it is interesting to consider whether the accounts given were influenced by the gender of the researcher. Would the male informants I interviewed have produced accounts that re-enforced their masculine identity in the same way if the interviewer had been a man?

To conclude, in this study the research relationship was only one factor among many which influenced the nature of health and illness discourse. Where account sympatricity (Stainton-Rogers 1991) has been reflected upon here it is clear that moral and religious discourses, gendered identity and social roles, stage of lifecourse, socio-economic status and 'race' position, as well as personal experiences, all influence the manner in which health and illness is understood and talked about. By studying the informant's accounts in detail it has been possible to show that there is considerable variation at the individual level in the accounts given and these factors interact in complex and varying ways.

5. CAUSES OF ILL HEALTH: PERCEPTIONS OF THE RELATIONSHIP BETWEEN SOCIAL POSITION AND ILLNESS.

5.1. Introduction.

So far evidence suggests that gender roles and gendered values influence the kinds of health accounts produced by informants in this research. It is also clear that gender is mediated by 'race' position, socio-economic status, and stage of life-course, so that these factors have influenced health accounts too. To explore the role of gender in health and illness experiences further, this chapter examines whether informants *perceive a connection* between their experiences of ill health and their gender position, and if so, which aspects of 'gender' are thought to be a risk to health. Section 5.2 explores the connections women and men made between their health status and gender roles. This was predominantly discussed by women, particularly those aged over 30 years. For those that made a connection, the struggle to perform successfully in their roles as carers was perceived to be the main contributor to ill health. Older women also discussed problems in their marriages which may be connected to gendered expectations held about marital roles for women. Younger women, who may not experience such fixed gender role expectations, were less likely to make connections between gender roles and ill health. Harry was the only male informant to make connections between male gender roles and his experience of ill health. This seems to reflect the fact that Harry, along with the female informants who also connected roles to ill health, felt he was not able to fulfil these expectations of him adequately. Therefore, it is the struggle to fulfil gender roles valued by informants that is perceived to be a risk to health.

Although gender roles are specifically pinpointed as potential risks to health, it is difficult to isolate effects of gender from the effects of other aspects of social position. Therefore, section 5.3 explores the connections between gender and health, made by informants, that reflect the interaction of gender, 'race' and socio-economic status. Several women and men do discuss perceptions that illustrate this, and these discussions relate specifically to experiences of employment. However, more significant is the fact that discussions about the effects of institutionalised racism reflect a perception that this is a collective

experience that moves across gender and life-course boundaries. This is illustrated in the way that women and men discuss the effects of racism to be connected to the health of the community as a whole, rather than in reference to personal health experiences. These connections are explored in this section. However, not all informants discussed either the presence of or effects of racism in its different forms. I briefly discuss this, and suggest that this might reflect a public account of racism, the development of which might be encouraged by the presence of a white researcher.

5.2. Gender social roles and expectations: a perceived risk to health.

Research addressing the question of how the experience of womanhood affects self-reporting behaviour among women has been prolific (see section 2.3.a, chapter 2). One suggestion has been that women may report more ill health than men because gender socialisation encourages women to perceive themselves as more vulnerable to illness than men (Saltonstall, 1993). However, findings in this study do not wholly support this argument. Although female informants are more likely than male informants to talk about emotional factors as a cause of illness, this is not consistent across all women interviewed, nor is it consistent that all men interviewed did *not* acknowledge emotional factors as a possible cause. For example, women such as Enid (aged over 50 years), Opal and Jenny (both aged under 30 years), although stating that emotional strain could affect health, were clear that it did not affect their own (see section 6.2.d, chapter 6 for a discussion of Opal's strategy for preventing emotional strain). In fact, it was also argued in the previous chapter that women value stoic behaviour, their ability to cope and their ability to meet the demands that their gender position makes of them. In addition, although most men were reluctant to characterise themselves as being affected by emotional problems, younger informant Harry did perceive his material circumstances and the obligations of fatherhood as factors that exacerbated a physical condition (see extract 1, table 5.3). Therefore, it is difficult to argue that the experience of gender socialisation is uniform for all women and men. It has already been illustrated in chapter 4 that gender socialisation is mediated by effects of socio-economic status and a racialised social position, which may also differ across the life-course.

Although women in this study were more likely to make connections between illness experiences and social position, this does not necessarily imply that women talk about ill

health more than men because they perceive their bodies differently, or because they act more emotionally, as implied in Saltonstall's work. Instead, it may suggest that the roles that women undertake expose them to more health problems than the roles undertaken by men. This finding is consistent with the suggestions of Nazroo, Edwards and Brown (1997), discussed in section 2.3.a, chapter 2. Therefore, women's and men's different discourses of how ill health connects to the wider context of their lives may be better explained by examining the roles that women and men perceive they are expected to engage in.

Women's discussions of gender social roles in this study suggest that it is the inter-personal relationships, whether care relationships or relationships with partners, that are most often connected to the onset of ill health. They discuss the strain of trying to perform these roles and how this may develop health problems, and it is these aspects of women's gender roles, as well as domestic roles, that I will focus on in this section and contrast with the limited discussion of these roles by men. I will also explore how these gender roles alter and become less significant to younger women who talk about causes of illness.

5.2.a. Women's care roles and the onset of ill health.

There was a general consensus that gender role expectations for older women involved caring for children and other family members and domestic chores such as cooking, cleaning and doing the laundry. The extracts suggest that women and men of various ages in this study thought expectations of women are more burdensome for them than the roles that men are expected to engage in. For example, field notes record (see extract 1, table 5.1) that older female informants perceived that *"women were more disadvantaged than men, having to work harder, getting less rewards, etc."* Older informant Denzil also expresses this by stating that *"I think women suffers a lot more than men"* (extract 2, table 5.1) in relation to the role demands that he has seen his wife struggling to fulfil. Melanie, of middle-age, argues that women are expected to provide care for all her family, as *"everything falls under woman"* (extract 3, table 5.1). In the same extract Melanie expresses a sense of obligation to fulfil these expectations, that women are *"supposed to"* undertake these care roles. Younger informant Robert's reflections on how the family cared for his father underline the understanding that women are expected

to be responsible for care rather than men. He refers particularly to the way that his mother delegated this care role to Robert's sisters rather than her sons: *"as long as there was another female in the house, which was normally my older sister then that responsibility ... would be handed down to her"* (see extract 4, table 5.1).

Not all female informants linked these roles to specific health problems, although many indicated that they could bring about ill health. This may be partly influenced by public discourse (see chapter 4). There is also evidence that informants do actively negotiate the demands that these roles make (these strategies will be discussed in the next chapter). However, Francise and Melanie, both middle-aged, did discuss their understanding of how caring for family members created health problems for them. Francise linked the stress created by her care obligations to her mother, brother and her children and grandchildren to the worsening of her hypertension, whilst Melanie explained how caring for her father had an impact on her physical and emotional health.

Although Francise talked predominantly of the current family problems she faced, it was clear that she also linked her experiences of hypertension to the other pressures that she has faced in her everyday life. She perceives the initial trigger for her hypertension to be finance- and work-related problems, and these continue to aggravate her illness (see also discussion in section 5.3 of this chapter). As her obligations to her family were creating a stressful situation at the time of the interview this framed much of her discussion. Extracts 1 and 2 (table 5.2) illustrate how Francise found her responsibilities of care for different generations of her family created worries that she felt exacerbated her hypertension. She talks particularly about the responsibility she feels to provide care for her mother in the Caribbean stating that *"I feel, as the eldest child and daughter, I felt that I should just go home and be with her"* (extract 1, table 5.2). At the same time she states that her brother is *"leaning towards me and I have to give him that support"* (extract 2, table 5.2). The pressures that she faces in fulfilling both of these care roles are exacerbated by the fact that her mother and her brother reside in different countries to each other. The choice of whether to remain in Britain or to stay with her mother in their home island in the Caribbean is made even more complicated by a desire to fulfil a further care role, that of providing for her own children and grandchildren in Britain.

Table 5.1. Descriptions of women's gender roles.

1. "They mentioned that women were more disadvantaged than men, having to work harder, getting less rewards, etc. This led to a discussion about how they were automatically doing certain jobs in the home, such as cooking, cleaning and washing, whilst their husbands and sons tended to do outside jobs (if any at all) like fetching from the shops, maintenance work, etc."
Field-notes to preliminary discussion to group interview A. Lines 7-11.

2. Denzil: [pause] I think that women suffers a lot more than men. ( ) Women, they're so strong. They're so strong it's unbelievable.
Interviewer: Yes, I know, I've seen that.
Denzil: Yeah. 'Cos for one thing, you know the extended family … when they come here and started a family then, there were no extended family. And the wages of the man was not enough so they had to go and do something as well. And then they had to find someone to care for that child. And to see them getting up in the morning, getting the child ready, getting everything, pushing them to the nanny or wherever they put, ( ) go to work, come back, pick them up, come home, do housework.
Interviewer: ∴ And have the men of your generation had to change to fit – after seeing their wives=
Denzil: =We had to change because erm, it's so funny. When I came here I could not cook. 'Cos men home never go in the kitchen. It's a traditional thing. And when my wife start having children, I have to learn to cook. My first few meals nobody would eat! [laughs]
Lines 187-203.

3. Interviewer: Are [herbal remedies] passed down through women then?
Melanie: Yes. Because normally women take on the role of caring, mothering, nurturing, everything falls under woman.
Interviewer: Oh right, okay!
Melanie: You know?! Yeah. Well, if a man is interested he might, but more or less I suppose he would learn from his mother or from his sister. And if he has any interest. But more or less it's the woman. You're supposed to be the mainstay of the family. Your head is hurting you, the child doesn't go shouting 'dad.' He go the first thing 'ma!' Anything happens 'ma', it's always ma.
Lines 743-753.

4. Robert: I don't really believe that my mum troubled my brothers for the fact that she saw them as young men. Although she trained us all in how to cook and how to fend for ourselves, that in her eyes was a kind of back-up system. Like, okay you find a wife, she can't cook a thing ... But it wasn't a case of her saying 'I need you guys not to go out and play football today, stay inside give your sister a hand. Tidy up, straighten up, make sure your dad's okay. Cook something for dad'. No, as long as there was another female in the house, which was normally my older sister then that responsibility, if it was handed down would be handed down to her.
Lines 573-581

Francise's discussion illustrates how these responsibilities are linked to gender expectations of women, both as an eldest daughter[1], a mother, and a caring sister. These role expectations are closely linked to understandings of femininity that are explored later

[1] The implications of this position within the family is also referred to by Robert in extract 4, table 4, regarding his elder sister's obligations to provide care for her ill father.

in this chapter. Francise clearly states that she perceives that these demands on her have precipitated a worsening in her hypertension condition (extract 2).

Another middle-aged informant, Melanie, also discussed the repercussions for her own health in trying to meet the expectations she had of herself as a provider of care and support for her father. The discussion in section 4.6.a, chapter 4, illustrates her belief that the worries this role created for her, and the physical exhaustion she experienced, led to the onset of a chronic condition.

Table 5.2. Linking care roles to experiences of ill health.

1. Interviewer: What other stresses, you've talked about work stresses, are there any other stresses that are in everyday life that might sort of make it worse? **Francise:** Well, I think for me it is my mother as well. My mother, she is at home, now she's got nine of us, we're all here. She was here too, both herself and father went back, he passed away and she's at home now. And I'm worried about her, she's [elderly] and everybody is in England. And I feel, as the eldest child and daughter, I feel that I should just go home and be with her. To be with her. Plus I've got my children and grand-children [in the UK], and I'm very close to my children at the moment, and grand-children. And I find sometimes ( ) of conflict – what do I do? … I'm trying to work out how I'm going to deal with this split responsibility. Lines 288-298.
2. Francise: I've been off work this week because my blood pressure was quite high last week. For the past two weeks it's been very high. And feeling very hot, very tired, sweating all the time, I really felt unwell so I went to the doctor. It was quite high. They have given me additional medication. And I'm not happy with <u>myself</u> for that really because the aim was to try and reduce instead. I went back this morning for a check up and it has actually gone down. That's within a week. But I am not happy with that. That's why I have a blood test this morning. And when I went to the doctor this morning looking to see whether I am diabetic as well. Because of the feeling I am having. Things have been particularly bad for me. My brother he's experiencing a crisis, has been over the past 2 years which came to a head – erm, I'd say from [several months ago]. And he's leaning towards me and I have to give him that support. Just as he was with me. He's not responding to any advice to see the doctor or to take counselling. He's not well, in mental distress, so it's been very bad for me this week. **Interviewer:** So that creates an extra pressure. **Francise:** Yes, it is. I was lying awake last night and I actually feel chest pains, and my left arm was quite heavy. Lines 47-64.

Although these gender roles are clearly connected to ill health in the accounts of these two informants, it is necessary to examine why other women do not experience similar outcomes of these roles when the evidence suggests that participating informants widely acknowledge that these roles may create difficulties for women. There may be several reasons for this. As suggested above, as part of a public account some women may be

reluctant to admit that these roles are problematic for them, particularly as female informants suggest that women are judged for not being successful as carers. It is also the case that some female informants have mediated these expectations in some form. The following chapter, especially sections 6.2.b and 6.2.d, discusses the resources women use to mediate the demands that they face. These resources are often concepts of an independent, autonomous 'self' with the freedom to choose whether to engage in the gender roles women are expected to fulfil. Choosing not to, and fulfilling other roles, may minimise the importance of being successful within these roles. Mediating expectations can have positive health effects. Thoits (1991), for example, suggests that the importance of roles to individuals, or 'role salience,' affects the way that difficulties presented by a role identity are interpreted and the development of a health problem (see section 2.3.a, chapter 2 for a discussion of this).

Although not all women experience care and domestic roles as salient, there is strong evidence in this study that *none* of the men interviewed experienced these roles as salient, although in several instances men are depicted as 'helpful' to women in performing household and child-care tasks. For example, in extract 1 (table 5.3) older informant Valerie talked about how child-care was shared between her husband and herself. Although her husband was helpful in bringing their child home, the implication is that Valerie would provide the main care role once she returned home from her work.

Denzil, also of older age, explains how men of his generation 'helped out' their wives who were juggling many domestic and care tasks, noting in particular his own contribution to cooking in the home (extract 2, table 5.1). However, he does not challenge the understanding that these tasks are primarily women's responsibilities. There is little indication whether younger men differ in their expectations of who is responsible for domestic and care roles.

Extracts from older informant Enid's interview suggest that her son at least does not perceive that domestic tasks are the responsibility of both women and men. Enid's laughter (extract 2, table 5.3) at the idea that her son (aged under 20 years) might be helpful in performing household chores outside of his own bedroom, illustrates how those chores are perceived by him to be her responsibility. The amazement provoked by another older female's son's helpful actions around the home (extract 3, table4.4) suggests that this may not be an uncommon experience for mothers.

Table 5.3. Responsibility for care /domestic tasks remain with women.

1. Valerie: [My husband] was working nights, I was working part-time. So by the time I come he used to bring the child them home, used to bring the child by the time I come. She never have to go out and stay the whole day or anything like that. He was always here and I was always there to come back. It was a beautiful time.
Lines 647-650.

2. Interviewer: Do you get much help around the house? Do you have a son=
Enid: =Not from him, no! [laughs] I mean I'm always telling him off! I mean, he looks after himself. he cleans his bedroom and whatever. 'Cos I decided I'm not doing that, but like, washing the dishes and helping and in the shopping, he's always busy, ALWAYS busy, got so much to do. According to him.
Lines 148-152.

3. Robert: I've learned now that I have to learn how to pace myself out and get it done. Or I find my wife would do it. If it's on the home side my wife will do it 'cos she knows there are certain things that I CAN'T STAND! She would do it.
Lines 80-82.

It is acknowledged here that the mother-son dynamic cannot be compared to a domestic situation where women and men are living together as partners, but it may imply that perceptions of 'who does what' at a young age might remain into adulthood.

Informants of middle-age noted during feedback session Eii that gender role expectations were altering among younger African-Caribbeans. Field-notes record that these informants *"felt that younger men shared much more because younger women would not put up with less, whilst their own generation did not challenge [these roles]"* (field-notes to Feedback session ii following group interview E, lines 129-131). This change in who is responsible for domestic and care tasks is also reflected in younger informant Robert's domestic situation with his wife and young children. Robert remains at home and undertakes child-care and house maintenance tasks in a joint decision made with his wife to enable her to go back to work. However, although Robert may share the care responsibilities for his children with his partner, it is clear that he does not feel he is ultimately responsible for household tasks. This was illustrated during a discussion of Robert's time management at home (extract 3, table 5.3). In particular, his statement that *"my wife will do it 'cos she knows there are certain things that I CAN'T STAND!"* suggests that his participation in household chores is more optional than his wife's participation.

So even where there is evidence that domestic and care roles are shared to some extent by partners, it is clear that these roles are still perceived as the responsibility of women

rather than men. As Nazroo (1997c) argues, the greater engagement of women in these roles can predispose them to more ill health than men. This may be particularly so if women value successful performance in these roles as salient to their identity. Significantly, although there was a consensus that domestic activities are part of the role expectations that women had of themselves, it was the care roles, rather than the domestic roles, that were linked by informants to their own experiences of ill health. This is illustrated in the cases of middle-aged informants Melanie and Francise, discussed earlier. It might be that domestic roles are more negotiable than care roles, both practically (for example, in extract 1, table 5.3, older informant Enid explains that she draws boundaries in household tasks between her and her son) and through the prioritising of 'self' over social role demands (see section 6.2.d, chapter 6).

Gender roles for men are rarely problematised by male informants within this study, except where work-related issues are discussed (see section 5.3). The exception to this is younger informant Harry, who believed that the pressures of providing for his children financially and physically whilst managing a serious condition causes difficulties for him (see extract 1, table 5.4). This is exacerbated by problems finding permanent accommodation and employment (see following section). Thus, similar to the discussion with Francise, gender role fulfilment is perceived to be closely linked to other life circumstances that in combination create health problems. Consistent with the public discourse of other men in this study, Harry seems concerned not to appear unable to cope with the pressure of managing his circumstances. This is illustrated in part by the brevity of his discussion about the difficulties he finds in meeting the expectations of himself as a father. Harry does not state that these difficulties exacerbate his condition, but it is feasible to suggest that they may make the management of his illness more of an emotional strain. This might be implied because of Harry's use of an account of health and illness which resembles Stainton-Roger's 'body under siege' account (1991), which depicts an individual to be under threat or attack from interpersonal conflicts and stress through the agency of the mind. Extracts 2 and 3 (table 5.4) illustrate this account. Harry talks about people questioning the nature of his illness prior to diagnosis as a stressful event. He states that *"it is very stressful, because everyone's saying 'what's the matter with you?'"* (extract 2, table 5.4). This suggests that Harry perceives such questioning to be critical of him, thus creating a conflict which is stressful. He also speculates that *"all the psychological upheaval and the trauma ... could have affected me"* (extract 3, table

5.4), thus making further connections between emotional conflict and his health status. In addition, his statement that *"you don't know when, you don't know where. It will just come on you like that"* (extract 2, table 5.3) suggests that he perceives the illness he suffers to be separate from his body and his 'self', and that he is at times 'under siege' from the effects of it.

The gender expectations that Harry tries to meet differ from those discussed by Melanie and Francise. Rather than providing essential care and support, he is concerned with providing for his two sons financially and with being able to take part in leisure/play activities with them. These expectations reflect the traditional division of gender roles, where the provision of financial stability for the family is primarily the responsibility of the father. Harry's marginalisation from employment as a result of his illness and his housing situation (the role of institutionalised racism in Harry's experience of housing allocation is explored later in section 5.3.b) effectively limits him from being successful in this particular gender role that he feels responsibility for. This may have implications for mental well-being when we consider the importance of functioning for men, discussed in chapter 4.

Comparison of Harry's experiences with other men interviewed in this study is difficult, particularly as no other male informant experiences a condition as limiting as Harry's. Of the four other men aged under 30 years and interviewed individually, only Robert has children, and although he does not work this has been a conscious decision, made possible because his family can rely on the income of his wife. Robert is also able, physically, to take part in his children's development and leisure time. Theo, aged between 30-50 years, did not mention children, but had worked for many years in this country. The other four older men interviewed all had children, but all were also in full-time employment during their working lives when they would have been expected to provide for them. In addition, they all remained with their marriage partners, who may, if the lives of other female informants are an indication, have also provided an income for the family. Therefore it is possible that the challenges Harry describes of not being able to fulfil the expectations of fatherhood have not actually been experienced by other male informants. This may explain, in part, why men in this study do not link emotional challenges of fulfilling expectations of men to their experiences of ill health i.e. they may not have experienced emotional challenges of this kind.

Table 5.4. Male gender roles and the 'body under siege' account.

1. Harry: So basically, what I'm saying the type of job I'd like to think that I've got something to offer, but what, what type of work would I be able to do?
Interviewer: Is there any guidance to help you=
Harry: =Well, I would do, but because I've had trouble with my housing, and they've said to me 'look, sort your housing out first' and then we can sort that out. But sometimes I just think it's such a dilemma really, because I was married before, I've got 2 kids must have been 23, 24, divorced, I've got an 11 year old, I've got a 19 month old, and you know, I'm their father, they still need money, and it's very difficult to support them and give them the edification that they need, because I find things increasingly difficult to do myself, you know, playing with them.
Lines 193-202.

2. Harry: You got no control over it. You don't know when, you don't know where. It will just come on you like that. That's how quick [my condition] is. You got no warning. All you can do really is just try and conserve your strength…
Interviewer: Is it quite stressful the fact that you can't control it?
Harry: Yeah, it is very stressful, because everyone's saying 'oh, what's the matter with you?' Before I knew, they used to say 'what's the matter with you, and how come you're walking like that' and you tend to, your foot tends to drag underneath you like that, rather than in a proper fashion like you would normally walk. That's why you have to look where you're stepping. It's very, IT IS very stressful, it is very hard.
Lines 280-296.

3. Interviewer: Are you in touch with your parents?
Harry: Yeah, that's another downside really, because [pause] because my parents had a messy relationship, messy divorce, erm, we got to-ed and fro-ed here and there. My sister and myself … We're made to feel guilty really, and we're just pawns just caught up in the sphere, it's nothing to do with us. But, you know, because it was my father, he treated her badly, it's like it's our fault. Who knows, because of all the psychological upheaval and the trauma that we've gone through in our lives, who's to say it could have affected me in that way.
Interviewer: Yeah. I don't know whether you have sort of stress=
Harry: =Yeah, I've had a lot of stresses, I've had a lot of stresses in my life.
Lines 382-402.

It is significant, however, that male informants did place emphasis on their physical ability to function in the work place, discussed in the previous chapter, and that retirement appeared to prove a challenge to the older male informants. This suggests that financial provision for the family might be a salient role for men as caring for the family appears to be for older women.

5.2.b. Partner problems are linked to experience of illness.

One outcome of the interviews in this study, that was not anticipated, was the number of older women who discussed health problems caused by either emotional or physical abuse by their partners. Writers such as Mama (1993) and Bryan, Dadzie & Scafe (1985) suggest that the abuse of women among black and minority ethnic women is an outcome

of the challenges of low socio-economic status faced by black and minority ethnic men. They suggest that racialised limitations on access to well-paid employment, and the consequent necessity for female partners to work in order to contribute to household income, limits men's ability to function in the way valued by traditional ideologies of masculinity. This, and the added difficulty of adjusting to women's growing financial independence with waged work, may create a sense of empowerment that some men are thought to respond to by asserting power in their close relationships. Findings by Foner (1979) support this argument to some extent. She found that the role changes that Caribbean women and men had to undertake on migration to the UK did create problems for those already married, particularly the growing financial independence that work opportunities in Britain offered women. It is also the case that, with the exception of older informant Kerri, *all* other females who were interviewed in this study had worked or were currently working. It is not possible to suggest whether the arguments by Mama (1993) and Bryan, Dadzie & Scafe (1985) are supported in this study particularly as the partners of those who experienced abuse have not been interviewed. However, earlier discussions in this and the previous chapter support the argument that functioning in a masculine way is important to men, and that there are difficulties for men when this is threatened. The number of women in this study who discuss abusive relationships may also give a false impression of the prevalence of the experience of abuse. The proportion of women who discuss abuse may be an outcome of the methodology of this research that has been to use community groups to draw informants. It is possible that individuals may attend these groups *because of* their experiences, and need for forms of community support. This aside, it is important to discuss these experiences because they are integral to the perceptions of health and illness held by these informants.

The reasons for abusive relationships are complex, and it is not possible to explore these fully in this discussion. Instead I will outline the ways that women connected ill health to their experiences of abuse, and then examine the role that gender expectations of women seems to have had in exacerbating the abusive situation. In particular, I will discuss the value placed on remaining within a marital/family unit, which has perhaps encouraged women to stay in situations where they are exploited by their partners.

Experiences of abuse and illness.

Several female informants, all aged over 50 years, discussed the impact they felt abusive behaviour had on their health. Cathy described the verbal and physical abuse that she suffered from her ex-husband. In her interview Cathy's discussion of her marriage ran alongside that of her health problems, illustrating how inter-connected she felt them to be. In particular, she connected the onset of diabetes to the stresses she experienced during her marriage: *"I was never told I was diabetic or anything. 'Til I had my first marital problems"* (extract 1, table 5.5; see also extract 2). Cathy explained that she was only able to control the diabetes once she became involved in a relationship with a new partner who was not abusive towards her (extract 3, table 5.5). Valerie felt that the heart attack she had was a result of an accumulation of marital difficulties that she experienced including physical violence: *"This heart attack I had. A lot of worries I had with that husband of mine. Come back and beat me"* (extract 4, table 5.5). In contrast to Cathy, Valerie found this more difficult to express, illustrated in the fact that she did not mention these feelings until well into the interview. This may be largely due to her concern to 'keep it all inside' (see extract 4), an expression of the values examined in chapter 4.

In group interview B, Ivy and Lisa also discuss their experiences of abuse. Ivy in particular talked at length about the mental breakdown that she experienced, which she connected to her husband's abusive behaviour. Field-notes record that Ivy implicates her husband in the onset of her mental health problems. This is illustrated most clearly when she states that, following a breakdown in the presence of friends, *"they offered to take her home. She refused and said she was going to her mother's. She didn't want to go back to a man who might put her in a mental hospital"* (field-notes to group interview Bi, lines 40-42).

Enid also discussed problems she experienced with an ex-partner that she suggested caused her worries (extract 5, table 5.5). However, her account differs to that of the other informants above, because she discusses the incident as a fixed and isolated point in her life that has no bearing on her present health. Other informants do appear to remain affected by these events, perhaps because they continued for a greater length of time, and perhaps because their experiences brought on more severe health problems.

Table 5.5. Discussions of abuse.

1. Cathy: … But when I came [to the UK] even going through my pregnancies and things like that, all my examinations never revealed any sugar [diabetes]. I was never told I was diabetic or anything. 'Til I had my first marital problems. And the strain and the stress of rushing to work, to and fro, to and fro, and I was bigger, I had a good size on me. The stress from my ex-husband and his carrying on I literally went, [pause] I didn't go mad, I didn't have a nervous break-down, but I was always tense, very tense.
Lines 39-45.

2. Cathy: And the last thing that I said to myself, [speaks quietly] no more, you are going to file a divorce. It isn't worth you getting sick. All this time my sicknesses coming on and I don't know.
Interviewer: Do you think that the diabetes was actually brought on by=
Cathy: =By that stress, it was. Even if it were there to come on, it was triggered by what I had to go through.
Lines 390-395.

3. Cathy: … That man, if he was my husband, there would be no divorce. 'Cos the man is a gentleman, you know what I mean? Stuck to his responsibilities everything. No fights, no rows, no abusive language, no hitting, no carrying on, no accusations … Peaceful ...
Interviewer: And that peace that you had then, did that help your health=
Cathy: THAT helped. Everything, my diabetes started levelling out as they call it, stabilising, coming down, 'til I got the hang of it then. And realised how to treat myself.
Lines 727-736.

4. Valerie: [long pause] Sometimes these men I tell you. Sometimes yes you know, sometimes, going back again, this heart attack I had. A lot of worries I had with that husband of mine. Come back and beat me.
Interviewer: That was quite near the time of your attack?
Valerie: No that happened [another year] but you know, go through all these things and you just keeping it inside.
Interviewer: So you think that something did contribute to the=
Valerie: =That's what I think.
Lines 660-668.

5. Interviewer: =Are there any incidents that you've had where your social situation has affected your health? I don't know whether your living environment, or people that you know, relationships that you've had.
Enid: Probably relationships– well I suppose it would have done at the time ... I was in a relationship once that erm, things weren't going well and er, we used to quarrel a lot. Erm. This was a man, used to threaten me and I wasn't happy with it and all that. Yeah. So it could be that. I don't know! [laughs]
Interviewer: How did that affect your health then? That kind of stress?
Enid: WELL, you worry from day to day, you worry when you go to sleep, you realise something not right and you want to get out of it. So you praying for the day when you can get out of it. Which I eventually did.
Lines 81-98.

Findings in this study suggest that older women other than Enid may, in addition to other physical and mental illness, have suffered feelings of failure or shame in the events of

their marriages. Some of the women who experienced abuse discussed their expectations of marriage. In group interview Bi field-notes record that Ivy explained that in the Caribbean *"it was normal for people to marry those your family approved of"* (extract 1, table 5.6), and that she *"believed he was her husband for better or for worse."* In the same group interview Lisa explained that financial dependence on her husband and an understanding that her children needed a father encouraged her to remain in her marriage until he took the decision to leave himself (extract 2, table 5.6). Valerie talks about what she perceives to be an ideal family situation: *"it would have been nice to say you're married and you and your husband and your family, seven grandchildren, you and your husband"* (extract 3, table 5.6). The desire to have this family unit was also expressed by a middle-aged informant, Melanie, to whom a boyfriend meant that she *"felt like [she] had a family unit again"* (extract 4, table 5.6).

Melanie's desire for such a unit, for someone to care for, she believes, led her to allow an ex-boyfriend to exploit her financially. This extract implies that it is not only marital status that may be important to women, but that being part of such a partnership or family unit allows women to undertake care roles, which are often salient to women's identity, as discussed in the previous section. Indeed, in extracts 5 and 6 (table 5.6) Brandy, also of middle-age, suggests that to be a single woman, and to be without children, causes people to *"stand back and they look at me and they say 'what is she at, what is she about?'"* (extract 6, table 5.6), questioning her 'femininity.'

The evidence suggests then, that as well as the actual physical and psychological harm abusive relationships have caused, salient roles may also have been challenged for those women who value a partner and family. Of the older women, the only ones who do not appear to value such roles so strongly, are Enid (see extract 6, table 5.5) and Kerri. Kerri's attitude was that *"as long as him no good, you know he get in trouble and so you know the man, then you try and live by yourself"* (lines 368-369). Both appear to prioritise the need to stop the behaviour they find unacceptable over the value of staying with the man in question. Therefore, these two informants do not express the same shame and failure as other older informants.

Table 5.6. Expectations of marriage and women's marriage roles.

1. "Ivy restarted again by suggesting that it was the way she was brought up, in a small place in a West Indian island … and that it was normal for people to marry those your family approved of. So, she said, she met her husband in her mother's home. Her mother knew his family and he was approved – and she believed he was her husband for better or for worse, she took her marriage vows seriously."
Field notes to group interview Bi. Lines 89-97.

2. "[Ivy] said it wasn't easy to leave your husband, especially as she had children and was of the opinion that children need a father. Here Lisa came in and said this was true. In those days you were more dependent on your husband financially – when [her husband] left she didn't know how she was going to pay for anything."
Field notes to group interview Bi. Lines 104-111.

3. Interviewer: You don't think you'll have another partner?
Valerie: [quietly] No. I don't need a partner, really … [pause] It would have been nice to say you're married and you and your husband and your family, seven grandchildren, you and your husband. Been married since in the West Indies. I was married before I was 21! Lines 675-687.

4. Melanie: Wake up in the morning it's myself, everything it's me alone. And from him coming and so, I was looking forward to his visits. I had someone to cook for, you know, Sundays when I come [to the service], go to church and then when I come back I just grab anything to eat you know? But I knew he was coming I'd put myself out to make dinner … because more or less I felt like I had a family unit again. And I knew he was coming and looking out the window, and when he comes I said I feel like my family's complete you understand?
Lines 595-607.

5. Interviewer: = I don't know whether at different stages of your life, people making comments and that kind of knowledge of what is expected of you, does that cause you problems, does that cause you anxiety?
Brandy: [quietly] Huh-hm. It has. I mean I've had to do a lot of reading to find ways of dealing with that, because for someone living on their own for a very long time and society has lots of expectations from you as a woman which I've not fulfilled? Part of it is to bear children, I've not fulfilled that … Erm, do people still regard you as feminine – well of course, you've not borne children, okay? I still regard myself as a feminine woman, but I know that people they say 'what are you waiting for? Why don't you have your children?' all these sort of questions. And what they're more or less saying as long as you have a child you are feminine.
Lines 260-272.

6. Interviewer: Okay. Are there any other expectations that you've been challenged with?
Brandy: Oh yes! Living on my own is another one. [laughs] Because, people cannot, I don't know … okay there might be men on their own but it's very rare that you find a black man on his own basically ... And therefore for a woman to be on her own without any children is a very rare specimen indeed. So to them, I think people stand back and they look at me and they say 'what is she at, what is she about?'
Lines 310-323.

It is significant that younger women do not describe experiences of abuse. It is difficult to pinpoint specific reasons for this from the interview material of this study, but it is

feasible to suggest that greater access for women to better careers over the last twenty years may mean that women's role salience has shifted. Success in jobs and careers may be just as valued as being part of a relationship and family. So that although these women may still aspire to being part of a couple and having a family, when this does not happen or when a relationship fails, they have other roles in which they can feel successful. Expectations of career success may in fact be increasing for women in contemporary times. Thoits (1991) argues that alternative salient roles may act as a safeguard from mental health problems. In conjunction with this, the discourse of self-governance offers women the chance to centre their own needs as opposed to that of a partner, which may encourage women to leave abusive relationships.

5.3 Intersections of gender, 'race,' socio-economic status and ill health.

The previous section illustrated that for some informants, gender roles did influence their experience of health and illness. When these informants discussed the relationship between gender and health it was sometimes evident that other aspects of social position such as 'race' and socio-economic status, affected health in some way. In section 5.3.a I will explore examples that illustrate how different aspects of social position mediate and exacerbate the relationship between gender and ill health. These examples relate in particular to financial hardship and racial discrimination in employment. In section 5.3.b I will explore the way that informants' often depicted institutionalised racism as a factor that affected health in itself, particularly access to housing and resources for the African-Caribbean community, and treatment by the police. Institutional racism is explored here because, where connections between racism and health are made, they illustrate an experience that is common to both women and men in this study, and is therefore not gender bound. This is made most explicit when informants refer to a collective experience of racism and to the health of the perceived African-Caribbean community. This more collective experience of the relationship between 'race' position and health and illness is in sharp contrast to the very personal and private experiences of the relationship between gender position and ill health. It may be that the 'collective' experience illustrated in this material may be particularly specific to minority ethnic groups, compared to groups whose common experience is economic and material

disadvantage, because of the shared minority ethnic culture and identity, and the position of minority ethnic groups at the excluded margins of society.

Although a significant number of informants discuss racism in relation to health, there was often a clear reluctance to do so. In fact, many older informants made statements that they had not experienced racism at all. It appeared that others were reluctant to characterise themselves as having been affected by racism in any way, although it is difficult to substantiate this using the research material in this study. What material exists is discussed in section 5.3.c.

5.3.a. Perceived health effects of gender, race and socio-economic disadvantage.

Explicit in the discussion of a few informants was reference to health effects precipitated by several aspects of social position, particularly gender, 'race' and socio-economic status. In section 5.2.a reference was made to Francise's perception that meeting the demands of her care roles was exacerbating her condition of hypertension considerably. Further into the interview Francise states that *"I found myself working here rushing from one place to another on my way home, and I felt my knees very weak and I wasn't able to make it indoors properly"* (see extract below), and that she was diagnosed with hypertension as a result.

> **Interviewer:** I was wondering about your hypertension and how you became aware of it … How did you find out=
> **Francise:** =Erm, I wasn't feeling very well. I remember well, I had my working hours reduced so my pay was cut, I was working part-time, and my mortgage had to be paid and other bills. So I was ( ) to work, apart from my part-time work I was doing agency work, I was going from one nursing home to the next. I found myself working here rushing from one place to another on my way home, and I felt my knees very weak and I wasn't able to make it indoors properly. And I was very weary and tired. Headaches and so on. I though the headaches were migraines, so I had a paracetomol. And I realised I was getting very tired and my eyes were sort of dry … So I took myself off to the doctor and he said to me that I've got high blood pressure.
> Lines 338-351.

Francise suggests then, that both her employment and economic status, and gender care roles, precipitated and exacerbated her condition. Harry's discussion, although brief, also makes reference to the intersection of gender and socio-economic status and their affects on his health (see extract 1, table 5.4). In his situation however, Harry's unemployment is partly due to the debilitating illness with which he suffers. This situation is also related to

his difficulties getting permanent housing from the council. He states that *"I've had trouble with my housing, and they've said to me 'look, sort your housing out first' and then we can sort [a job] out"* (extract 1, table 5.4). In response to my question whether racism may be involved in the difficulties he faces attaining housing, he states that he *"wouldn't really like to play the race card"* (line 94) but finds it difficult to explain the delay otherwise, when his disability makes him a priority candidate for re-housing. Therefore, for Harry, multiple circumstances of disadvantage create a 'catch-22' situation, which exacerbates his difficulties in meeting the role demands of him as a father and provider.

Other informants discussed the intersections of gender, 'race' and socio-economic status in terms of access to employment and their experiences in the work place. Melanie, aged between 30-50 years, felt that her anxiety about finding a job, in combination with the end of a relationship, may have led to the renewed onset of symptoms related to her condition. Significantly, she notes that her job search, for a position in the legal profession, may be hindered by perceptions of her 'race' and class: *"is it because of my race, is it because of that, is it because I don't belong to such and such a class, you know?"* (extract 1, table 5.7). Younger informants, Bruce and Graham, talked specifically about the difficulties young men faced in getting employment, although they do not relate these directly to health. Graham felt that *"it's harder for a black male than a female, you know? Being male I don't get so much chances as a female would"* (extract 2, table 5.7), implying that this was due to positive discrimination towards women because of sexist attitudes. He suggests that high levels of unemployment are having detrimental effects on the health of individuals in the black community: *"a lot of them are without jobs, you know, they can't see a way out. A lot of them are alcoholics"* (extract 3, table 5.7).

Bruce also suggests that access to employment for young black men is affected by their criminalisation: *"a lot of them have criminal records and stuff, that's not of their own making ... they don't even feel very bitter, but it stops them from getting other jobs"* (extract 4, table 5.7). It may be that Bruce understands the criminalisation of young black men to be related to negative, racialised, stereo-types, as indicated in Bruce's comment that the *"white community is more threatened by a black male that a black female. Don't know quite why. Don't know whether they're thinking all these nasty people ... but they feel very uneasy with black men"* (extract 2, table 5.8).

Table 5.7. Connections between gender, 'race,' socio-economic status and health.

1. Melanie: Cos who knows why these latest [symptoms] I've been having is not a combination of that so called failed romance with inverted commas, plus you know, anxiety about getting jobs, and this and that, and wondering say well I've been to school like everybody else, is it because of my race, is it because of that, is it because I don't belong to such and such a class, you know? …
Lines 489-493

2. Interviewer: I mentioned 'race' and gender, and how that might create pressures, or take away pressures perhaps, I don't know how you feel, I don't know whether you're conscious of being male in Britain, or whether that's=
Graham: =Yes, well, being a black male. It's harder for a black male than a female, you know? Being male I don't get so much chances as a female would you know.
Interviewer: Right. Why is that? Do you think?
Graham: Well, it's the way that the system is, you know, colour, you know, other matters and that. It's the way the system is.
Interviewer: I'm just wondering why women get more chances.
Graham: Yeah, becau:se, well say for instance, a white employer would tend to employ a black female than a male 'cos maybe they like, you know, a female, you know, as a sex symbol and all that, they tend to give them a job more often than they would give a black male.
Lines 181-192.

3. Interviewer: How does [racism], do you think that makes a kind of illness for the black community as a whole?
Graham: Yeah it puts the black community under added pressure, you know … I can see the black community, a lot of them are without jobs, you know, they can't see a way out. A lot of them are alcoholics, they just can't make a headway.
Lines 128-134.

4. Interviewer: Do you see that [racism] is having an effect on the health of the community?
Bruce: It does have an effect, especially guys my age, I'd say. A lot of them have criminal records and stuff, that's not of their own making. They've been set up, framed, got assaulted, violent conduct … and stuff, it stops them from getting, ahhh.. They don't even feel very bitter, but it stops them from getting other jobs. So if you want to work with children and stuff … it really stops them from making career moves ... their doors are blocked. So it's all kind of 'ah!' frustrating and because I know exactly where they're coming from. You think gosh this is grossly unfair, and no-one's going to listen to your side of the story. So they've trapped, you try to help yourself, it's so unfair. You are still channelled, because of your past, you can only go a certain way.
Lines 219-235.

Some informants noted that racist/sexist treatment in the work place might have health-related effects, particularly mental health. For example, middle-aged informant Clare discusses a friend who experiences mental health problems as the result of such treatment, although she notes that the friend is 'susceptible' to mental illness. Despite this, Clare argues that *"if you constantly feel abuse at work from people ... it will affect your health condition"* (extract 1, table 5.8).

Such treatment is not exclusive to women. Bruce refers to his time as a sales person where he experienced at first-hand the effects of racialised stereo-typing. He found that

white customers would rarely come to him for a sale, because, he speculates, white people appear to perceive black men as threatening (see extract 2, table 5.8). He describes the necessity, in such a situation, to make his voice sound more 'white.' He suggests that the strain of racialised stereo-typing and it's effects *"takes it's toll"* (extract 2, table 5.8) on some people, implying, it seems, difficulties in emotional well-being. However, he states that it has not affected his own self-esteem.

Older informants make reference to discriminatory experiences in the work place during their working lives, suggesting that although the ideology behind racism may have changed over time[2] the practice of it has not. For example, Denzil refers to the unequal pay conditions for newly arrived migrants (see extract 3, table 5.8). This situation would have been exacerbated by the fact that black people at this time were not represented by trade unions, making it easier for employers to exploit this source of labour. It has been suggested by writers such as Foner (1979) that the financial hardship created by low pay meant that newly migrated wives had no choice but to find work, as was the case for Denzil and his wife (see extract 3, table 5.1), contributing to the role load for women at this time.

Albert also talks about his difficulty in attaining work to match his skills as a trained builder. He recalls answering an advertisement for a position he was qualified for, only to be told by the employer *" 'I won't give no black bastard no skilled work man job' "* (lines 192). Field-notes record that Lisa experienced the same discrimination, being told that *"there was no job for her [at the exchange]"* (field-notes to feedback session following group interview B, lines16-17) with the implication that she would not be given a job because of her colour.

---

[2] See Blaut's theory of 'cultural racism' outlined in section 2.3.d, chapter 2.

Table 5.8. Health effects of racism and sexism in the work place.

1. Interviewer: We've talked about the struggles a little bit, how do they affect health?
Clare: It could really affect your health in the sense that if you constantly feel abuse at work from people, so far that you, it will affect your health condition … I mean I've got a friend now, I mean she's susceptible to mental illness, but I think a lot of it's, some of it's to do with work and how people relate to her at work, and because she's susceptible to mental illness anyway, it takes very few instances to trigger her off=
Enid: =Hmm.
Clare: And think she's being persecuted because she's probably schizophrenia, so a lot of people the work situation of racism and sexism can lead to illness if you don't have a support network. Because even for women, not just black women, but women who are in [male dominated] professions as well they also suffer from sexism where they feel abused … I think it affects your, not only mental health, but your physical health, cause if you're not whole, then you have all kind of illness wrong with you. Group interview Ei. Lines 591-607.

2. Interviewer: Do you ever feel that the pressure's on men a bit, like you were saying about racism, and even walking down the street []=
Bruce: … I feel, from what I've picked up, the white community is more threatened by a black male that a black female. Don't know quite why. Don't know whether they're thinking all these nasty people and the poor black woman's being suffered by, or what they think. But they feel very uneasy with black men ... [In sales] you have to put on this [laughs] what I call my 'sports stars name', then the British public will love you, when you just sound very white, I can really put it on. 'Cos when I go in the shop and speak on the phone I get so much appointment. I turn in – [customers] come into the shop and you can see 'oh', then [they make excuses and leave] … that's nothing new, and MEN will get that much more than a women. Because I suppose with a lot of men … they don't feel intimidated by women. Say if a [sales] woman comes over they think 'ah, I'm sure I could sweet her up' so [sales women] bring them in … But I had no joy! [laughs] I only had ONE, two white customers, all the rest were black.
Interviewer: Now does that affect your self-esteem? Or have you learnt to deal with it?
Bruce: Well thank goodness it hasn't affected mine, but I know a lot of people it has. It takes its toll. Lines 468-508.

3. Denzil: You come in and you get the lowest pay.
Interviewer: But you=
Denzil: =But you doing the same job. And that used to cause a lot of conflicts, because there was a lot of genuine natives, who come to you and say 'see how much you getting'. 'Cos they know. And you say '10 pounds a week'. '10 pounds a week?' And they would swear and tell you, 'nah, here's my pay packet' … in those days a lot of companies – they used to take a lot of liberties with us. When we first came.
Lines 454-465.

Evidence discussed in this section does seem to corroborate with that of earlier studies. Donovan's findings (1986) from interviews with an east London sample of African-Caribbean informants suggests that racism is a pervasive experience for women and men, and that it is most often met in the workplace, both in the form of verbal abuse and in exploitative power relationships. Her informants suggested that stereo-types about African-Caribbeans held by British people was a main factor leading to discrimination, and that experiencing racism could have negative effects on health.

5.3.b. Perceptions of institutionalised racism: a collective experience.

As discussed at the beginning of this section, some informants, especially middle-aged participants in group interview Ei, were explicit in their view that forms of racism are important to consider as potential causes of ill health. There was a collective view that white people *"see the colour first"* (see extract below) and that this informed the way that a lot of white people responded to them, inviting practices of racism.

> **Interviewer:** Does anyone else find that people erm, that white people, just for argument's sake, white people actually see the colour more than you yourselves?
> **All:** General chatter in agreement.
> **Clare:** I feel they see the colour first.
> **Enid:** Yeah, definitely.
> **Clare:** Because I think in terms of the black population, they don't see us as a professional they see the colour first in most instances. When in the Caribbean probably to a large extent if you're a professional person they really look up on you, but here you've got racism to deal with. Your looks or whatever, your colour comes first.
> Lines 195-205.

This extract implies that, because informants felt they are judged by their colour above everything else, aspects of 'race' position are often more relevant to consider in terms of health than gender. A later discussion with the same informants also suggested that 'race' was more important to consider that class status when examining experiences of disadvantage. Field-notes record that *"although there were differences of opinion there was agreement that class did exist, but that was not as important as 'race' when assessing disadvantage, because all black people had low status in this country"* (field-notes to feedback session ii following group interview E, lines 64-67).

Informants of the same group interview discussed the fact that being identified as black creates problems in accessing resources. Dorothy expressed strong feelings about the way that *"because of my colour some people might think that well I shouldn't have <u>access</u> to certain things"* (extract 1, table 5.9). In particular, Dorothy mentions discrimination in access to housing, and this is an issue other group members also made reference to. Avril suggests that African-Caribbeans in Hackney are automatically allocated public housing on estates with bad reputations for crime and disrepair (extract 1, table 5.9). Enid links the poor condition of housing provided by Hackney council to ill health, suggesting that *"children might start getting asthma and bronchitis and all kinds of things innit, so it just revolve around itself and course you're gonna get stressed"* (extract 2, table 5.9). Field

notes record that one community group co-ordinator,[3] who commented on the 'questionnaire' used in group interviews, also linked habitation in housing located in deprived areas to mental health problems (extract 3, table 5.9). Enid, in group interview Ei, also makes reference to the council's lack of response to the poor quality of housing stock, suggesting that even when the council are notified of problems *"they're not doing anything about it"* (extract 2, table 5.9). Although younger informant Harry's comments are in reference to the specific housing needs demanded by his condition, his frustration at what he perceives to be the council's inertia in finding him adequate housing (Extract 2, table 2.6), appears to corroborate the understanding expressed in group interview Ei that the council is not reliable in it's provision of resources. It is not clearly stated whether this lack of action by the council is perceived to be part of institutionalised racism. However, racialised allocation of poor housing means that African-Caribbeans, and other minority ethnic groups, are more likely to be living in what are perceived to be unhealthy environments (see discussion in section 2.3.d, chapter 2).

Informants in group interview E discussed other forms of discrimination that they connect to health problems, including their perception that research into illnesses experienced by black people has been given very little funding in Britain. Clare refers specifically to under-funding of research into sickle cell anaemia, both in the extract below and in extract 2, table 5.9. She suggests that this not only exacerbates the condition for sickle cell sufferers but, perhaps because of the discrimination, may *"put more stress on the black community which give us more ill health"* (extract 2, table 5.9).

> **Clare:** With some illnesses that are particular to black people you're more stressed in the sense that there isn't enough research done in it. You know, like sickle cell for instance, a lot of sickle cell, sicklers, could live a more comfortable life if only the government put it on the same footing as they put another, other ailments=
> **Enid:** =[murmurs in agreement]
> **Clare:** =That affect the majority of the population …
> **Dorothy:** One less black person is=
> **Brandy:** =[laughs]
> **Dorothy:** Is one less to worry about.
> Group interview Ei. Lines 713-728.

[3] This discussion took place during a first meeting with a co-ordinator of a group that did not participate in the study.

Table 5.9. Racialised access to housing.

1. Dorothy: I think - nothing, I know so. That because of my colour some people might think that well I shouldn't have access to certain things, how dare you demand this or want this, and I at times might feel aggrieved even though I don't dwell on it … I've been working hard in this country long before some of them were born. I help pay taxes to pay their school fees, to subsidise their university degree … And then people turn round and say 'well you not entitled to' it's not about entitled to, it's I contributed and for that contribution I expect certain things. Whether I get it is another matter.
Interviewer: Right. How does everyone else feel about that?
Avril: I agree with that. Especially you mention public housing. The minute you fill in the categorised section 'are you Caribbean?,' immediately, I suppose it's whose dealing with it, 'oh [allocated to problem estate]'.
Group interview Ei. Lines 455-469.

2. Clare: So even that, even the fact of diagnosis and the fact of funding for issues and illnesses that affect black people, put more stress on the black community which give us more ill-health.
Interviewer: Yeah.
Enid: And you know which can go on to cause more stress and more problem. Also if you live in a one-bedroom flat with 3 or 4 children, which is damp, no proper central heating, and you keep going up to the council, they not doing anything about it, course it's going to affect your health, plus your children might start getting asthma and bronchitis and all kinds of things innit, so it just revolve around itself and course you're gonna get stressed.
Group interview Ei. Lines 722-740.

3. "He liked question 10, saying that racism does affect mental health. He felt that I should follow up the issue of social deprivation, such as housing and whether a clean environment exists, as he felt that these can lead to depression."
Field notes 16.1.98. Discussion with co-ordinator of Hackney Caribbean community group.

4. Harry: … Like my housing I'm still in a homeless hostel, been there 18 months … I need somewhere that's accessible for my needs, fairly spacious, but within Hackney they don't seem to cater for that. I mean that's WHY I've been so long on the waiting list. When I went there initially I was told 6 weeks. 6 weeks, you know what I mean! And I've been there gone 18 months and I'm still there.
Interviewer: That's a long time isn't it.
Harry: It's a long time. And they say things are getting better, [councillor] is saying they're doing this, they're doing that, but they still not doing a lot at all!
When it comes to disabled people they say 'oh Hackney cares' and they're catering for special needs people, but they're not really doing much, and they're not doing enough, I don't think.
Lines 20-33.

Dorothy's contribution to this particular discussion, that *"one less black person is one less to worry about,"* reflects a real sense that a general disregard for black people exists.

Comments were also made within this group interview which suggested that group members perceived the allocation of resources to community groups to be influenced by racialised local politics. Field-notes record that informants argued resource allocation to, and support for, black community groups in Hackney was limited (extract 1, table 5.10). This was despite the fact Hackney is represented by a black Member of Parliament, and

has the largest black population in east London. They suggested that *"when funding is scarce ... the council cuts funding to black groups first"* (extract 1, table 5.10)[4], implying that racial discrimination informs this decision. In a different way, older aged participants of feedback session Aii in Newham also discussed racialised allocation of funding for community groups. Their comments reflect the particular position of groups providing for African-Caribbeans. There was a collective understanding that resources are more likely to go towards funding provision for non-English speaking minorities, particularly Asian groups, which in effect discriminates against African-Caribbeans. (see extract 2, table 5.11).

Table 5.10. Problems accessing resources.

1. "I also asked whether the borough, or being within a predominantly black area helps create a sense of power/esteem. I was met with faces of mock horror – their view was of a borough whose council provided very little support for black groups. When funding is scarce, they argued, the council cuts funding to black groups first. Because of this there is a lot of pressure on black groups to meet targets and 'prove your worth'. Any wrong move could result in funding cuts. Such pressure they said means that workers take on more unpaid hours and unsociable hours which can put a strain on health. When I asked about support from black politicians they felt that their presence was not helpful either because they are more willing to pledge support to white groups because they don't want to be labelled/associated solely with black groups."
Field notes to feedback session ii, following group interview E. Lines 79-92.

2. "When [the co-ordinator] joined the group and we broached the subject [of community resources] again, other things were discussed. There is a sense that most of the community groups and statutory efforts are aimed at the Asian community because of the perception that language barriers create the greatest problems. Because African-Caribbeans are English-speaking they are not so serviced. The co-ordinator feels that statutory people don't always help in directing African-Caribbeans to resources such as their community group."
Field notes to feedback session ii following group interview A. Lines 95-101

3. "Diane made the point that [the community group] played an important role in helping people find out about resources and aids and that those more isolated in the community had much lower access."
Field notes to feedback session ii following group interview A. Lines 51-53

Racialised allocation of resources may have health effects in different ways. Informants of group interview E felt that the pressure to *"meet targets and 'prove your worth,'"* (extract 1, table 5.10) created by competition for resources, forced community group

[4] My own observations during the initial stages of this project support these comments. Whilst trying to find groups to participate in this research I often found that Caribbean groups in Hackney had short life spans, primarily because of cuts to their budget by the local council or organisations such as East London & the City Health Authority. Others had to cut the services they provided and rely on volunteer workers.

workers to work unpaid and unsociable hours which had health affects.[5] However, limited resources for community groups may have indirect health effects also, when community group members are provided with services relating to their health and well-being, which are then reduced or removed. In addition, it may be that some community groups assist African-Caribbeans to access resources (extract 3, table 5.10) when statutory agents fail to do so, as is suggested in extract 2, table 5.10 and extract 2, table 4.1 (chapter 4).

In light of the recent Stephen Lawrence debacle, it is useful to note that criminalisation of young black men by the police is also discussed by informants in this study. Comments by younger informant Bruce suggest that a lot of young black men *"have criminal records and stuff, that's not of their own making. They've been set up, framed, got assaulted, violent conduct ..."* (extract 4, table 5.7). This supports James' (1993) argument that younger African-Caribbean people in Britain in particular *"experience a greater degree of state harassment, and indeed some brutality at the hands of the police"* (James 1993: 273). Older informants also noted the treatment of young black men by police. Enid talks about her teenage son's experiences of being stopped by the police and questioned about drugs. Her comment, *"soon as a black boy is there ..."* (extract 1, table 5.11), reflects a widespread understanding that the 'stop-and-search' strategy is heavily racialised. Winnie also discusses the treatment of young black people by the police, referring to an incident that she witnessed between a young African-Caribbean and a police officer, and an article in the local newspaper highlighting this issue of racialised policing.

Bruce suggests that criminalisation in this way has effects on access to employment (see discussion earlier in this section), and this may have negative mental health outcomes, particularly when employment may be a salient role for men. More indirectly, the extracts of Enid and Winnie illustrate that parents of young African-Caribbeans live with worry and fear for their children.

---

[5] Some of the group members were community group workers themselves.

Table 5.11. Treatment by the police.

1. Interviewer: What about your son? Does he suffer from any racism? Is it different for different generations? **Enid:** Yeah, I think he does. I mean, he don't tell me but for him it would be with the police really. When he's walking the streets and they stop him and say to him, ask him 'where's the drugs' and all that. Soon as a black boy is there … **Interviewer:** How does that make you feel as a mother if you know that's going on with your children? Does that make you worry= **Enid:** =Of course it does make you worry, you never know, every time he goes out and doesn't get back late, or doesn't come in 'til late, or then the phone rings, you worry because you know, you don't know, you always think it might be the police there now, or something or other. But I mean, I don't dwell on it. Lines 322-346.
2. "Winnie felt that not enough was being done for black people, especially those with mental health problems – she referred to seeing people on the street being mad, and people being sectioned for no reason. Nasreen agreed, and said that Care in the Community was not working either – there was a real sense of being failed. Winnie said that it really depressed her seeing the treatment of black people, and she referred to a particular incident where police had picked on a young black man. She also talked about an article in the Gazette reporting on an incident where a man had been stopped by police 32 times over 2 years – and there was no reason for this. She felt that this made her fearful for her kids." Field notes to feedback session following group interview B. Lines 97-107

5.3.c. Discourse of resistance.

Despite the connections made among several informants of racism's potential effect on health, it is significant that just as many informants did not discuss this link. Many of the older female and male informants stated that they had no personal experience of racism. For example, Benjamin was very adamant that he had not encountered racism, stating that *"I haven't had the experience, so there's nothing I can say about it"* (extract 1, table 5.12). Cathy is also certain that she *"never had no problem with nobody. Not that [racist people] weren't there, but I didn't meet it up"* (extract 2, table 5.12). Albert does discuss one incident of racism (see discussion in section 5.3.a above), but states clearly that it was the only incident he has experienced, and that it didn't affect him, taking it as *"one of those things in life"* (extract 3, table 5.12).

Table 5.12. 'Denial' of racism.

1. Interviewer: Just talking about coming to England, did you have any experience of racism, or do you now? Is that=
Benjamin: =No, I never undergo that.
Interviewer: No. Not even=
Benjamin: =Never come across it. But I've HEARD, but my personal self, I never experienced it.
Interviewer: Right. [pause] Not even through your work?
Benjamin: No. No.
Interviewer: Oh, right, that's good. I mean, again, I've heard as well, I'm just trying to find out=
Benjamin: Now with me, I haven't come across this. But I've heard other people come across it.
Interviewer: Does it worry you that it's out there?
Benjamin: Nah! Not until it occur to me. And erm, and I've got personal experience of it. Then I can talk of it. But I haven't had the experience, so there's nothing I can say about it.
Lines 332-343.

2. Interviewer: I was just thinking back to the focus group that we had, a long time ago now=
Cathy: =Hmm.
Interviewer: There was talk about how being black in Britain was kind of a bit of a stress.
Cathy: No, that didn't give me any stress … I remember telling you that from the time I came to Britain, I never had no problem with nobody. Not that they weren't there, but I didn't meet it up. All the people, white people that I circulate around, I had to be mixing with, were quite respectful to me because I never use obscene language, I was never boisterous to them, I never talk down to nobody … So I had never that. Nobody never tell me 'we don't like you or your blackness', no. None of that.
Lines 897-916.

3. Interviewer: When you [experienced racism] applying for that job, how did that make you feel at the time?
Albert: No well, I pass through – I just take it as one of those things in life.
Interviewer: Right. And you haven't experienced anything since then?
Albert: No.
Lines 209-213.

It is difficult to accept that individuals of this generation have experienced no racism at all considering the scale of racism that does, and has, existed since their arrival in Britain. When this was put to middle-aged participants during a feedback session group members shared this difficulty in acceptance. Francise suggested that, *"there is a large denial of racism in the older generation"* (field notes to feedback session i, following group interview E, lines 20-21) a view supported by Krieger (1990), who found in her sample of American black women that those aged over 45 years were more likely to keep quiet about and accept racialised treatment than younger women. It may be that 'keeping quiet' about racism may have been encouraged by the degree of guardedness amongst older informants in this study about discussing experiences of health and illness, which, as discussed in chapter 4, was based on insecurities due to prior experiences of racism. It

may also be that 'keeping quiet' reflects the value placed by older informants on being able to cope with life circumstances, and religious values of tolerance, which are both discourses that are present in health and illness accounts, explored in chapter 4. Despite evidence pointing to these explanations, it should be remembered that it may be the case that some informants have simply not experienced racism.

Middle-aged informants, and those aged above 25 years, were more open about their experiences of racism, as is illustrated in the fact that material in this section regarding racism is mostly drawn from informants aged under 50 years. This might be partly explained by the influence of the Equal Rights movement of the 1970s, that may have encouraged the understanding that black people have the right to demand equal treatment and access to resources. It may also be that they are responding to the legacy of ill-treatment that has been experienced through their parents and grandparents. The ideology of equal rights does not appear to be shared by many older informants. Instead, their narratives suggest that they are more likely to tolerate their treatment, reflecting, perhaps, the value given to 'making do' and being 'satisfied with their lot.' These values are emphasised in the discourse of older male informants such as Charles, who talks about being 'satisfied,' but are clearly absent from the discourse of younger informants who are, perhaps, influenced by a more contemporary rhetoric of striving for a better quality of life.

Although younger informants are more likely to speak out about racism and discrimination, most informants do not comment on the effects racism has on them personally, choosing instead to discuss the effects of racism at a community level. Some informants are particularly keen to suggest that they are not affected by racism. Bruce emphasises this by saying that *"funny enough with me, doesn't get to me. But when I watch stories and see the brutalities, the injustices, it gets me. But with me, when it's faced in my face and stuff like that ..."* (lines 189-191). In a similar way Graham states, in reference to racism: *"I can handle it you know. But sometimes it just gets on top of me. But I can deal with it, you know. I don't allow it to bother me, you know?"* (lines 101-104).

It may be that denial of racism and distancing oneself from it's affects acts both as a public account to guard oneself, but also as a strategy to mediate the effects of racism. The use of representing oneself positively is discussed in the following chapter.

5.4. Conclusions.

Findings in this chapter suggest that aspects of social location are perceived by informants to create 'risks' to their health. Stresses in life associated with gender roles, for example, are clearly connected by many informants to the onset of a wide-range of illness. Fulfilling expectations of care roles is a particular risk for women, and for some fulfilment of marital roles and expectations has also created health risks. In contrast, male informants do not make connections between gender roles and ill health. This pattern is notable mainly among older informants – younger women in this study did not perceive their gender roles to be a risk to their ill health. I have suggested that these patterns might be explained by the gender identities informants adhere to, which were also referred to in the previous chapter. It appears that older and middle-aged women value their care role within the family above many other roles, reflecting a traditional understanding of women's roles. When these female informants have faced difficulties in fulfilling these roles, therefore challenging their self-value and sense of identity, it has led to distress and other health problems. In contrast, younger women in this study value other roles alongside care roles, particularly work-related roles, and therefore the potential for distress when difficulties are faced in fulfilling one kind of role may be off-set by fulfilment in another.

Men in this study appear to value work roles above others, and the majority of informants were either in employment at the time of interview or had been during their working lives. Many then, with the exception of Harry, had fulfilled the roles of salience to them, perhaps explaining why male informants did not perceive a connection between gender roles and ill health. It is significant that Harry, unemployed and finding difficulties in fulfilling his paternal duties, was the only male to make a connection between gender roles and ill health. There is little evidence in this study that younger men value other roles besides work roles, except Bruce, who values his role as parent above this. With this in mind it is of concern that there is growing evidence of high unemployment among young black men, also noted by informants in this study. There are implications for the health of this group of men if difficulties in achieving valued (work-related) roles has the same health affect that informants discuss in this study. There is then, much scope for further research into whether young men are valuing other roles (and whether the

pressure to be 'macho' actually prevents them from taking up roles that are perceived to be 'feminine'). The question of how unemployment might be impacting on men's health is also important.

Another important finding is that many informants explicitly connected their 'race' position to the potential for ill health. The way that this is manifested takes several forms: through racialised access to employment, discrimination at work, and the various effects of institutional racism, all of which informants felt placed pressure on individuals and the black community, leading to further health problems. Community group 3 in particular discussed institutional racism in access to resources. It should be noted that this community group was fairly politically charged, and all members had direct experience of working with, or for, a wide range of community services in their locality. This is not to refute the points they made, particularly as informants in other community groups corroborated these points, but to suggest that these comments were charged and not necessarily typical of other informants. The role of local politics and racial equality in access to resources had a significant influence then, on the interview discourses of some informants. Participation in this study may have provided a chance for these individuals to express their frustrations, thus directing the interview discourse to a significant extent.

The processes involved in directing the interviews are significant. Throughout this study I have been sensitive to 'race' social positions and racialised inter-personal dynamics which has led to the tendency to prioritise 'race' issues over others, such as socio-economic status during the interviews. The sensitivity to 'race' issues has been reinforced by informants positive response to my approach and their discussion of racialised experiences which may reflect the fact that, as suggested above, this study has given informants an opportunity to express their views about racism. Parallel to this, informants may have found it easier to discuss racialised experiences rather than other factors. For example, evidence in section 5.3.c illustrates that where racism is discussed, the effects of this are talked about at a community level, and informants often make the point that racism doesn't affect them *personally*. In contrast, other issues that were personal and did affect informant's own health, such as partner abuse, were more difficult for individuals to discuss. It may be that informants found other factors such as personal income levels and living environments difficult to discuss, particularly if they felt judgements would be made about their inability to be successful in life. Where the researcher was more

sensitive to comments about 'race' rather than economic disadvantage, these aspects of informant's lives were not discussed. As a result, evidence in this chapter does not reflect comprehensively all the 'risks' informants perceive their social location to hold, but provides an in-depth insight into the ways in which gender social position can affect health and how this is mediated by racialised experiences.

6. Examining The Process Of Empowerment In Health And Illness.

6.1 Introduction.

In chapters 3, 4, and 5 reference has been made to the way that informants mediate experiences related to social position and health. In particular, I have noted that withholding access from the researcher, and the use of specific kinds of discourses in health accounts, are significant aspects of the process of mediation. In this chapter, with reference to the ideas of counter-power and resistance outlined in section 2.4, chapter 2, I will explore forms of mediation more closely. In particular, I will examine how strategies of mediation draw on resources of culture, and how informants use the medium of an interview to develop representations of themselves that act as resistance.

These strategies are individual actions, and do not always represent a political motivation, or even a consciousness of resistance. In fact, it is largely unclear what does motivate informants to use these strategies and resources. It is likely that, as Burgess and Pile (1991) suggest, human emotions are powerful motivators, particularly when safety and security are threatened. However, as these emotions are not openly discussed, in they are consciously recognised at all, the discussion in this chapter remains fixed on the strategies and resources themselves, rather than the emotions that encourage their development and use.

The structure of this chapter reflects the difficulties in discussing the strategies used by informants in an abstract way. Informants do not use one strategy, but several, and often multiple strategies are discussed in response to the same circumstance. In addition, a strategy can be an amalgamation of different resources. As a consequence, whilst this remains an abstract discussion of resistance, I will explore resistance through the interviews of four informants, selected arbitrarily. Prior to discussion of these informant's extracts I will outline the main strategies and resources that I have identified in their transcripts.

6.2. Challenging and resisting perceived effects of social location.

The strategies and resources discussed in this chapter are by no means exhaustive, and serve mainly to illustrate the process of mediation that takes place and how informants make use of cultural resources. The strategies I have noted fall into three broad categories: active resistance to circumstances, use of discourses of identity and belonging, and seeking guidance (see table 6.1). Active resistance strategies were strategies informants referred to in their previous or present experience. They were discussed either in relation to acts of racism or experience of physical/emotional abuse. They involved confronting the perpetrator, protest through withdrawal of services and custom, and becoming involved in activities which created ways of empowering others facing similar situations. Where gender role expectations of women were perceived as problematic for health, active resistance included rejection of these roles. These strategies often brought about change in circumstances for informants.

Table 6.1. Schematic view of strategies and resources used by four informants to mediate life circumstances.

Strategies	Resources	Denzil	Cath	Bruce	Opal
Active resistance	Black resistance			•	
	Caribbean Community	•		•	
	Self-governance		•		•
Discourses of identity and belonging	Strength/morality	•	•	•	
	Caribbean culture	•		•	
	Christian faith		•		•
	Self-governance				•
Asking for help	Black women's collectivity		•		
	Christian Faith in God		•		

Discussion of active resistance also involved the use of discourses of identity and belonging, so that these two strategies were often inter-linked. Discourses used involved representing oneself as embedded in and living up to particular group values, whether of strength, morality, Caribbean community identity, as a Christian or as self-governing. The discussion in section 2.4.b, chapter 2, about the positive mental health effects of 'belonging' may indicate that by characterising themselves as part of an accepted collective identity, informants may be promoting a sense of self-worth and self-esteem. This is particularly relevant when informants use this strategy to discuss their experiences of discrimination and disadvantage which has been shown to have detrimental health effects (see sections 2.3.c and 2.3.d, chapter 2). The discourse of self-governance appears to work in two ways. Firstly, it encourages a sense of 'self' that is This understanding of 'self' corresponds with that which is advocated by psychology and which has given rise to the proliferation of self-help groups and counselling (Nettleton 1997). As such it has provided a means for some women in this study to reject gender social roles that are disempowering and perceived to be detrimental to health (this strategy is, therefore, categorised here as 'active resistance'). Secondly, achieving the values of self-governance, such as developing an individual's sense of control over all aspects of their life and minimising risk creates an identity that connects an individual to a collective value, although, ironically, it is an identity of individualism, not of community.

'Seeking guidance' is the third strategy. This is not necessarily a strategy of active resistance, although it could precipitate such actions; neither is it a discourse of identity or belonging, although reference to this strategy may also represent an individual as 'belonging' to a group or to a faith. This strategy seems to work primarily by providing a means to share worries and anxieties. However, it also offers a means to place isolated personal experiences into the perspective of a more collective experience, which can be empowering, and can minimise sense of failure. This strategy may also offer a source of advice regarding direct action.

These strategies draw on cultural resources such as meanings and values held by Caribbean culture, Christianity and self-governance; values of strength and morality (suggested in chapter 4 to be related to gender and working class cultures); and ideologies of Black resistance. It is difficult to state whether uses of strategies and

resources can be differentiated by gender, although women use 'seeking guidance' predominantly more than men. However, it is possible to discern that age group broadly corresponds with different ideologies. Younger informants are more likely to be influenced by neo-liberal ideology (including self-governance), both young and middle-aged informants are influenced by the civil rights movement (including Black Power), and older informants hold more conservative, more tolerant ideals. Each of these ideological influences seem to define ways of living life and coping with experiences which may direct informants to particular kinds of strategies of resistance. This life-course difference will be explored in the following sections.

The remainder of this chapter illustrates how informants used these strategies to mediate circumstances, through the accounts of Denzil, Cathy, Bruce and Opal.

6.2.a. Denzil.

The resources that Denzil uses to mediate life circumstances become apparent in his discussion of racism and prejudice in Britain. This centred round his experiences during the first few years following his arrival in this country. Denzil refers to specific actions taken during these years to counteract the effects of racism that helped to mediate problematic circumstances of the time. This discourse of resistance may in itself offer a form of empowerment. The notion of resistance can hold meanings of strength and courage and morality in the face of immoral and exclusionary practices. However, Denzil does not claim this moral identity for himself, but for what he perceives as the Caribbean community around him in London. During much of his interview Denzil juxtaposes Caribbean and Western lifestyles, suggesting that Caribbean ways are more moral. Denzil's claims about Caribbean ways suggest that he has a sense of belonging to the Caribbean community and his understanding of its cultural traits. This seems to encourage mental well-being (see chapter 2) and therefore is another means of mediating problems. Below I will discuss these strategies of resistance in more detail.

6.2.a.i Active resistance: community action

In his discussion of the difficulties experienced by Caribbean migrants arriving in Britain during 1950s and 1960s, Denzil refers in particular to living conditions and

access to housing. He suggests that racial exclusion, evident in landlords' stipulations of 'no blacks' (extract 1, table 6.2.) resulted in limited access to housing so that Caribbean people were living in rooms without bathrooms (extract 2, table 6.2.). As a result, he suggests, people responded by buying houses that had bathroom facilities (extract 2, table 6.2.). Denzil argues that the set up of 'partner' initiatives enabled people to buy housing by providing members of the scheme with

Table 6.2. Denzil: Community action.

1. Denzil: Now imagine you were invited here, we were invited here and you come and you see 'no blacks'...
Lines 81-82.

2. Denzil: The houses for [Caribbean] people to rent were the [laughs] lowest. Imagine you coming from the West Indies where you can get a shower and you come here and you get a house to rent without a bathroom … and toilet outside … we have to go to the community centre for a bath. Communal bath. And you pay a shilling for a communal bath.
Interviewer: And you did that, were you really able to push that aside, or did you=
Denzil: =No, you couldn't push it aside. One had to get in there and correct it or do what you can. So people start buying houses … and a bathroom is always the number one thing.
Lines 85-97.

3. Interviewer: And how does, I'm just thinking what you were saying about buying houses, was there any money there, were you able to get jobs?
Denzil: Erm, this is one of the things that I said about us getting together as well. We had a thing which we call 'partner', I don't know if you know=
Interviewer: =No, I don't think so=
Denzil: =What do you call it here? It's like you put your money in a Christmas thing=
Interviewer: =Oh, right, like a co-operative=
Denzil: =Yeah – yes. Every week you put in 5 pound, about there so, and everybody – like there's 10 of you in it that's 50 pounds. And your draw this week, so you can go pay down on a house.
Interviewer: Right I see. That seems like a good system.
Denzil: That's how it works. That's how a lot of us get a house.
Lines 130-141.

money to cover down payments which were difficult to afford (extract 3, table 6.2.), not least because of problems acquiring well-paid employment.

The partner initiative is an example of resistance in a very practical form. It is also significant to consider as it represents counter-power in another form. Denzil's discussion of the scheme suggests that it relies on the collaboration of Caribbean people, indicating that for Denzil this scheme might represent a collective group identity that he feels part of. That this group 'owns' an initiative that counters the effects of racial

prejudice, and which works successfully outside of the mainstream British system for obtaining housing, also promotes empowerment to those in the margins.[1]

In contrast to Denzil's reflections that collaboration between Caribbeans was successful, the comments of younger informant Graham, about business oriented collaboration, suggests that community level strategies to tackle problems of marginalisation may have changed over the generations. He feels that *"not enough [black men] is motivated enough ... some of them can't be bothered"* (see extract below).

Graham: Yes, well, being a black male. [attaining employment] is harder for a black male than a female, you know? Being male I don't get so much chances as a female would you know …
Graham: =But I believe that black men can get around that you know, by getting together and helping themselves, you know?
Interviewer: Oh right, yeah.
Graham: Start businesses, and that, they could get round all that, you know? Do what the Indians are doing.
Interviewer: Supporting themselves?
Graham: Yeah.
Interviewer: Is that happening much in the community here?
Graham: Yeah, it's happening slowly. But er, not enough of them is motivated enough. Some of them can't be bothered you know, but things is changing. It's changing.
Lines 184-210.

It is difficult to pinpoint why community level collaboration may be difficult for African-Caribbeans today, but comments by many informants refer to a perception that there is a loss of connection to Caribbean culture. This might suggest that 'Caribbean' identity is becoming fragmented, leaving little sense of community. This may, in part explain the change. Interestingly, Graham contrasts the lack of motivation among Caribbeans to 'Indians' (see extract above), indicating that he perceives this minority group as more successful that African-Caribbeans in collaborative initiatives.

6.2.a.ii Discourses of identity and belonging: Caribbean ways.

Embedded within Denzil's narrative about living in a racialised Britain is the positioning of what he understands to be 'Caribbean' ways against the exclusionary practices he experienced. Denzil discusses 'Caribbean' ways in a way that suggests they

[1] Forming 'Caribbean' churches, or joining existing Pentecostal churches, in response to exclusionary practices in mainstream British churches also promotes empowerment in a similar way.

reflect the actual character traits of Caribbean people. In particular he stresses the ability of Caribbeans to enjoy themselves, stating that *"as a people we love to enjoy ourselves"* (extract 1, table 6.3), and be emotionally and spiritually expressive (extracts 1 and 2, table 6.3). Denzil juxtaposes these traits alongside his experiences of the police and Western churches with the effect of actively challenging the legitimacy of racism whilst simultaneously celebrating what is perceived as 'Caribbean'. For example, Denzil contrasts the collective ('Caribbean') enjoyment that was derived from parties with the action of British police to place limits on this (extract 1, table 6.3). Later in the interview Denzil contrasts the value of spiritual expressiveness, that he identifies with, and the more sombre services of Western churches and the lack of action taken by the churches to support black people globally through their experiences of racial oppression (see extract 3, table 6.3).

Reinforcing the claim to Caribbean culture over Western ways was the sense of triumph in the mainstream recognition in Britain of an element of Caribbean culture. Denzil notes the contrast between earlier attitudes towards black people laughing and enjoying themselves and the health messages that are emerging today: *"now I see that people are saying, it's good to laugh. Laughing is therapeutic. And we've been laughing from day one and they've been trying to stop us from laughing"* (see extract below). Denzil also makes similar comments about the incorporation of Caribbean trends into British fashion designs too.

> **Denzil:** Erm, as we were saying, you go, and people are smiling and talking, some of them will say 'what are you laughing about, what you see funny?' Now your having a laugh and a joke. Because we like to laugh and these things help to, you know? Keep you sane-ish!
> **Interviewer:** And some people had a problem with that?
> **Denzil:** With you laughing, yes. And now I see that people are saying, it's good to laugh. Laughing is therapeutic. And we've been laughing from day one and they've been trying to stop us from laughing. Lines 478-485.

Informants in group interview Ei make similar claims to the Caribbean culture over 'European' ways. They note the influence of colours in English fashion that they argue has been influenced by the fashions of minority ethnic groups, and are also derisory about the versions of alternative medicine that are emerging, which they claim have been *"established for donkeys years."* In a similar way to Denzil, they juxtapose the adoption of alternative medicine with previous attitudes they experienced when they

practised the same medicines before it was 'trendy:' *"when we came here and was using our bush [the attitude was] 'these people are really dopy'"* (see extract below).

> **Dorothy:** And then also, is a classical example is all these fangle-dangle European version of alternative therapy and alternative medicine=
> **Clare:** =Established for donkeys years=
> **Dorothy:** =When we came here and was using our bush=
> **All:** [general laughter]
> **Dorothy:** Our, 'these people are really dopy' and now it's trendy=
> **Enid:** =Even offer it in the clinic now=
> **Dorothy:** =It's called alternative medicine, right, and is the middle-classes … is you know, it's the in thing isn't it? … It's now all, it's so chic=
> **Clare:** Even with our clothes, they, English people are very dark and cold people=
> **Enid:** =Yeah, they are all black=
> **Clare:** =Now the influence of all ethnic minority they wear all kind of colours.
> Group interview Ei. Lines 815-832.

Denzil's challenge to racialised practices suggests that there is a moral undertone to his discussion. It is this sense of morality that may provide Denzil with a resource for building a sense of worth, both as an individual and as part of a community, which mediates the effects of the racialisation he has experienced. However, it is difficult to disentangle morality as a resource from the sense of belonging to 'Caribbean' culture that also acts as an important resource for Denzil. Both are very much intertwined, particularly when moral behaviour may be perceived to be upheld by Caribbean institutions such as the church. That this perception might be held was indicated by an older male informant during a feedback session. Field-notes record that he stated Caribbean religion *"was important in maintaining moral standards"* (field-notes to feedback session ii, group interview A, lines 71-75).

Table 6.3. Denzil: Characteristics of Caribbean people.

1. Denzil: Erm, I think one positive thing that came out of [the discrimination], is it draw us closer together. It did. Because anywhere you were you see a black person, you go out of the way to go and start a – to talk, how they do, where you from, that kind of thing. That link. And then we start having parties ... And invite people. We're having a party, bring your friends along, bring a bottle, and we sit and we enjoy. And that kind of thing take a lot of pressure off you because as a people we love to enjoy ourselves. So then, when that happen the police come. You're making too much noise.
Lines 119-127.

2. Interviewer: So – I don't know whether people have kept going with the old religions more – have people set up their own churches now?
Denzil: Yes. Thank the Lord. Yes. Erm, you will find if you go all over the place, you will find various churches. But churches that cater for <u>being</u> as a person, like even today, I sit and I watch the television, and I see churches where people are going in and getting really [claps] hyped up.
Interviewer: Right.
Denzil: You know? I suppose, 'cos that's what the whole thing is about. Spiritual, uplifting. And yes. And when I look and see dancing there, there are a mixture of people there, and everybody's getting happy. Rejoicing () But the old church () and you go in and you sit down and minister and he preach to you, and I sit down and I [mimics nodding off]
Lines 273-283.

3. Denzil: There are a lot of people that feel disillusioned about religion – not religion. Not religion. Churches.
Interviewer: Churches – Church of England are you talking about, or Methodist?
Denzil: Churches.
Interviewer: Right – in general?
Denzil: Churches. Yes, the two biggest churches are the Church of England and the Catholic Church. And I think we should get some kind of () towards people. None of them EVER said anything towards the pressure that people feels and they know, they know what is happening. Even say what is happening in South Africa. I've never heard a pope get up and say 'it's wrong, stop it!'
Lines 259-268.

Denzil's discussion of his use of medicine and diet also illustrates the ways that different resources are used simultaneously. In the extracts below Denzil's sense of belonging to the Caribbean culture is expressed through his regard for Caribbean remedies. He understands these to be better than tablets prescribed by British doctors *"because there's no chemicals in bush [remedies]"* and therefore they do not have side effects (see extract 1, table 6.4).

Table 6.4. Denzil: Caribbean remedies as a resource for identity.

1. Interviewer: I don't know whether you've used any herbs as a treatment?
Denzil: Yes.
Interviewer: And I don't know how coming to England affected that?
Denzil: Yes. The thing is, coming here and you catch a cold, you get a cold and you go to your GP and you get the tablets. [pause] You stub your toe and you go to the GP and you get the tablets [laughs] Yeah. And you have a headache and you go to the GP and it's tablets again. And for every tablet you take, you get side-effect. Now a lot of us use bushes. Because there's no chemicals in bush. And even when we're here we will send home, can you send some like cerose or whatever.
Lines 327-337.

2. Denzil: But then, whenever I go to the West Indies I don't take tablets.
Interviewer: Do you have, is there a bush there that you=
Denzil: =There's a lot of things that you can use. AND my [blood sugar level] drop when I=
Interviewer: =Oh really?=
Denzil: =Every time.
Interviewer: Really? Do you know, do you sustain the same diet you have in England? When you go there?
Denzil: I eat everything out there. I eat everything.
Lines 350-358.

3. Denzil: I do a lot more walking, but deliberate exercise no. I get up a lot earlier as well. As the sun comes up – and more fresh fruit. Because I'm on the fruit until breakfast time. I never have breakfast until about 9, because there's all different kinds of fruit. Have a coffee and I'm on fruit until 9. And it's fresh.
Lines 375-378.

Thorogood (1990) suggests that this is common to many Caribbean people and the knowledge of remedies has become an important way for people to sustain their links with the Caribbean, even if the remedies are not regularly made or taken in Britain. Other informants also discuss health practice as a connection to their culture and their past. Clare states that *"if our child's ill, we decide what's in our medicine cupboard or what we can do from our historical past or what our grandparents show us, to get the child well first. We would rarely just go and call the doctor"* (from transcript to group interview Ei, lines 896-898). The significance of a link between generations provided by knowledge about remedies is also noted in the interview with Melanie. She states that *"I live together with my Grandma, she's still alive, still strong ... Now if I'm like my Grandma, got all this medicine outside my door. Even now Grandma, when I go down home, Grandma's got all them herbs."* (extract from transcript to interview, lines 665-669).

Denzil endorses this by suggesting that Caribbean remedies are better than his prescribed tablets for diabetes. He states that *"whenever I go to the West Indies I don't take tablets ... AND my [blood sugar level] drop"* (extract 2, table 6.4). In extract 3 (table 6.4) Denzil explains this as mostly due to the change in diet and lifestyle. An understanding that these factors in the Caribbean may promote better health was noted in the discussion prior to group interview A. Field-notes record that informants *"commented on how going to the Caribbean / home made many of their illnesses experienced in England disappear. They tended to explain this in terms of sunshine and vitamin D, better /more healthy foods and more vitamins"* (field-notes to preliminary discussion, group interview A, lines 1-4).

It is worth noting that Donovan (1986) suggests that depression can result from the repeated reflection on "idealised, stereo-typical views" of life in their Caribbean island homes (Donovan 1986: 230). However, this was not clearly discernible in this study, despite repeated references to 'home' life among many informants. There were informants who appeared sad when talking about the 'homeland', but this emotion was not expressed verbally to the interviewer. Instead, as suggested in this section, reminiscence and the act of connecting to a Caribbean identity appeared to have the opposite effect for some informants, creating a resource for mediating difficult life circumstances. That these findings are not consistent with Donovan's may reflect the different samples used; many of the older informants that were interviewed in this study had visited their island home in recent years and a few were making plans for a permanent return there.

There is also evidence that some older informants in this study felt that their 'home' should be in Britain, near to their children and grand-children. The importance of supporting younger family members may be reflected in another finding, that older informants are frustrated and worried at the treatment younger African-Caribbeans receive at the hands of the police and health services today. Blakemore & Boneham (1994) also note this in their review of findings, and they suggest that such frustrations "raise deeper questions about what black people have been able to achieve in British society" (Blakemore & Boneham 1994: 64).

6.2.a.iii Asking for help: prayer

In contrast to the discussions of other older men, Denzil makes reference to the support he derives from prayer, stating that *"prayer help build the mind. It helps you focus and when you finish praying, yes you feel uplifted"* (see extract below).

> **Interviewer:** I mean, have you deliberately used prayer to bring about well-being, or is it just something that happens, do you know what I mean, when you've consciously or deliberately used it, or is it something that's just there?
> **Denzil:** Prayer. [long pause] When I pray, I'm speaking about me. When I pray I pray whole-heartedly. I pray for you. I pray for everyone. I ask for forgiveness. I ask for togetherness, which, you know. But erm, yes, prayer help build the mind. It helps you focus and when you finish praying, yes you feel uplifted.
> Lines 305-311.

The fact that Denzil describes this resource may indicate that the health and illness accounts he uses reflect private understandings about the nature of ill health. However, it is equally likely that outlining this strategy is also part of a public discourse that reflects concerns to be characterised as a person of faith. So that making reference to this may reflect both a discourse of identity and belonging, and a means of asking for guidance. Denzil's accounts illustrate clearly then, the complex interweaving of different resources that influence the variety of strategies he outlines.

6.2.b. Cathy.

As with Denzil's discourse, Cathy uses different resources to mediate her circumstances, although her discussion centres around the experiences of abuse, which she felt was connected to her health problems, rather than experiences of racism. Her discussion of the active resistance she made in her relationship with her husband also illustrates the use of resources to promote feelings of self-worth. In particular, Cathy emphasises certain personal characteristics which she values, including courage, independence and the ability to work hard. These connect to public discourses of morality and function discussed earlier in chapter 4. Cathy also discusses friendship and Christian faith as a support. These also offer ways to mediate circumstances both practically and as a means to building self-worth. These latter resources appear to be used predominantly by women in this study.

6.2.b.i. Active resistance: centring 'self.'

Cathy describes the direct action that she took in response to her husband's efforts to dominate her. These included acquiring a car in order to secure her independence, sterilising herself so that her husband could not *"give her a child every year [so that] she can't move left or right"* (extract 2, table 6.5), and refusing his demands for sex (extracts 1, 2 and 3, table 6.5). These actions are important forms of resistance and suggest that although the husband maintained his power over Cathy through physical abuse, Cathy's actions challenged this to some extent.

Table 6.5. Cathy: Resistance to partner abuse.

1. Cathy: After I got my car, it was a present from my mother because I passed my nursing exams right through. Got my merit, everything, pass first time. And she said what would you like? I said well mum, I would like a car so that I can be independent so I can go from A to B so I don't have to ask him to take me. Because anytime I ask him to take me it was always an excuse he … got to do this, got to do that. He isn't my driver, he isn't this, he isn't that.
Lines 149-160.

2. Cathy: [My husband's] motto was, if you give her a child every year, she can't move left or right. Now my, I have 8 children for him [gives details of children] And the last child was my last child I intended having in this whole world for him. She born [year] and she was the last. And I remember that day that I went to my old doctor ... I says I am a pure Bajan, right? And I am one that speaks its mind. And I'm not happy with this situation I am in. He said 'all right, don't worry. You'll get your baby. Now would you agree if I get you sterilised while you are in there?' I says 'AMEN! Of course!' And no sooner did I say that, I am telling you, he was on the phone making arrangements to have it.
Lines 171-189.

3. Cathy: But the part that got on my nerves is, and I will go and tell the whole world that any married person having problems don't let no man abuse you and then tell you you must have sex with him. NO MAN. If he can't respect you physically then I don't see why he should want to have sex with you. That is showing he can do as he likes. Domineer you and you've got to give him sex. Now me, I got more beating for that because I refu::sed to have it. Definitely refused to have it. And I didn't hide and tell you 'well, I got headache,' this that - I'm telling you ain't hitting me downstairs and then coming upstairs and then telling me that you want sex …
Lines 101-107.

4. Cathy: Kim, I am a very (self-willed) person. I do not jump when anybody says jump. I have to wait at first. And if at the end of the wait I am comfortable in jumping, I will jump. I will do it in my own time. And there's no point in anybody bullying me, harassing me, hitting me, hitting the children, carrying on [pause] 'cos I ain't hearing you.
Lines 80-86.

5. Cathy: I begin to weigh up things and say 'well you don't deserve this. For what you puts into this home, and what you puts into the children, and how you treat that man, you don't deserve to be treated the way you're treated. Now you've got to put a stop to this. You've got to get out of this … And the last thing I said to myself, [speaks quietly] no more, you are going to file a divorce. It isn't worth you getting sick.
Lines 382-391.

6. Cathy: I used to do night. The minute I walked through that door I never remember my home, switch right off. When I get to the [workplace], not rude, not doing anything stupid, not lost in my memory, not forgetting this – MORE efficient I became. Because then, that was my work. No pressures … And when I'm doing that, that is me there doing that. No thoughts about what's going on here. I didn't have a home when I'm in there.
Lines 66-72.

6.2.b.ii Discourses of identity: strength

However, Cathy presents a version of events through hindsight, and it is therefore equally important to consider how she represents herself within this narrative, and how this representation might be a resource itself for mediating the effects of this experience. It is important to note that of all four older female informants that were interviewed individually, and others in group interview B who have had some experience of mental or physical abuse at the hands of their husbands or partners, only Cathy has talked about these experiences openly. Clearly, recollection of this part of their lives can be painful and difficult to relate to others. Another reason may be that informants are conscious of the stigma about being a victim and in being seen to not 'stand up' for oneself. Cathy, in contrast, talks about these events openly. It may be that she is able to do this by representing herself in ways that are morally acceptable. This might be as courageous and defiant in the face of abuse. This is illustrated when Cathy emphasises her steadfast refusal to have sex with her husband after he had beaten her. She states that she *"didn't hide and tell [her husband] 'well, I got headache,' … 'I'm telling you ain't hitting me downstairs and then coming upstairs and then telling me that you want sex'"* (extract 3, table 6.5). This representation of herself is re-iterated in her emphasis of her 'self-will,' and the fact that she does *"not jump when anybody says jump"* (extract 4, table 6.5). She also characterises herself as a good wife and mother (extract 5, table 6.5), and as an efficient worker (extract 6, table 6.5). Representing oneself in this way may in itself promote a sense of self-worth. Such representation also challenges the morality of her husband's actions, vindicating her from blame. Thus, although Denzil and Cathy discuss different power relationships, the representation of Caribbean v racial oppression, and Cathy v abusive husband, have very similar outcomes.

It is significant to note that Cathy does not use Caribbean identity as a resource for mediating life circumstances. In fact, she makes it clear that she has *"more problem with my own black people than with any other. Because my black people the majority of them, forget where they come from"* (see extract below). She does then, distance herself from this identity. This may be in part a response to the abuse that she has suffered from an individual from the Caribbean. This interpretation is supported by the fact that Valerie, who also experienced abuse from her Caribbean husband, distances herself from her Caribbean identity in a similar way.

> **Cathy:** I have more problem with *my* own black people than with any other. Because my black people the majority of them, forget where they come from … When you meet them good they good. They're nice. But when you get them that who are ready to abuse you and ready to tell you rubbish, they the ones who cause trouble all the time. And it all stems from one word in the West Indies, jealousy. You should not come here and qualify for anything, especially if them ain't got nothing. Now you don't ask them their business but they will hate you for the way you dress, the way you walk, the way you talk, if you got a good singing voice, the way that your healthy laugh. The cut of your teeth. They are the things they will hate you for.
> Lines 987-997

6.2.b.iii. Seeking guidance: friends and faith.

Cathy mentions two further resources that are of importance to her, talking with a close friend and her faith in and prayer to God. These resources seem to offer Cathy two ways to mediate life circumstances: through guidance when faced with difficult choices and by enhancing feelings of self-worth.

Cathy states that talking to a close friend about her husband's treatment of her eased the tension she felt by helping her forget her husband's *"nonsense"* (extract 1, table 6.6). The supportive role that talking to a close friend has for Cathy seems to work in different ways. Talking *"about men in general and their behaviour"* (extract 1, table 6.6) may promote a sense of solidarity which may provide Cathy with a means of vindicating herself from blame. Remembering a shared past with her friend also seems important providing, perhaps, an alternative frame of reference regarding herself that exists outside her marriage.

Table 6.6. Cathy: Guidance from friends and faith.

1. Interviewer: That talking actually eased the tension [induced by your husband's behaviour]?
Cathy: It eased the tension. Because then I was visiting my friend and we sit down and we talk about men in general and their behaviour, and how we used to live when we're growing up, how we used to get on, how we used to fight!
Interviewer: So even those memories helped as well, helped keep you strong?
Cathy: They helped me you see. And then I completely forget him and his nonsense.
Lines 245-250.

2. Cathy: And see the thing is you can prayer. Whether you is Christian or not, you must pray. Always ask Him up there to help you.
Interviewer: Had you been praying, had that been a support for you as well? When you were actually being abused?
Cathy: Yeah! I used to cry in prayer. Yeah! Because you see I was brought up in the church and I always pray.
Interviewer: Because I know you said you didn't turn to anyone else to begin with.
Cathy: No. Just God knew, I told Him all. I asked Him to show me a way, show me what to do.
Lines 481-489.

'Talking' was a strategy that only female informants discussed (Melanie also refers to this in her health and illness accounts, discussed in section 4.5.a, chapter 4). This may reflect a widely held understanding among informants that women and men tackle problems differently, often with the suggestion that this was due to women and men being socialised to respond to problems differently (see extract below).

> "I then opened the discussion to talk about why women might react more 'emotionally' to problems than men. Francise felt that women demonstrate stress through emotions whereas men might use anger. Women tend to keep things down for longer, and then explode! There was a sense that men were more hedonistic and that women were more 'strategic' in dealing with problems. They are more likely to use their brain to tackle situations, by talking to themselves and weighing up consequences (Francise). Dorothy and Enid joked that when they came to the end of their tether they lost their temper and got angry; later they admitted though that this would be the last straw – talking and negotiation would be the first strategy."
> Feedback session ii, following group interview E. Lines 98-109.

Women were expected to reason through problems, and 'talking' to others may be an important part of this process.

In addition to close friends Cathy explains that for her prayer has been an important means of receiving guidance (extract 2, table 6.6). This extract also suggests that prayer

offered Cathy a means to talk about her problems when she felt she could not talk to anyone else. The importance of prayer as a means of *"support through difficult times"* (extract 1, table 6.7) was recorded in field-notes to feedback sessions where this strategy was discussed. Older informants made clear statements that faith was important to them as a means of dealing with life circumstances and health problems. Extracts in table 6.7 illustrate this, and field-notes record that it is the hope and comfort that informants primarily derive from their faith.

For Cathy, prayer prayer also provide a guide in decision making. She states that during the time she was experiencing abuse *"I asked Him to show me a way, show me what to do"* (extract 2, table6.6). Prayer as a practical guide is also important for Brandy. She states that she asks *"'look, I'm not sure what to do with this. What is my course of action? What am I supposed to do?'"* (see extract below).

> **Interviewer:** Do you use prayer and that kind of faith to give you power to do something else?
> **Brandy:** Well, I don't know whether I get empowered as opposed to [pause] erm, lets say I've got decisions to make … I might say 'look, I'm not sure what to do with this. What is my course of action? What am I supposed to do?'
> Lines 403-429

However, although extract 3 records that informants felt that both women and men value faith, it is predominantly women who discuss this in terms of health beliefs. There are however, exceptions to this: Harry, Denzil and Bruce also talk about the role of faith in keeping them healthy. The more general gender differences among informants in this study, in reference to discussion of religious faith, may partly reflect the fact that men are more likely to use the 'body as machine' public account than women, whilst women's accounts reflect accounts incorporating spiritual and emotional health too.

Table 6.7. The importance of faith and prayer for other informants.

1. I asked about the importance of faith as a support through difficult times and there was a strong testimony from Rose that faith had been important to hold onto and stopped many people going back to the Caribbean. Feedback session 1, following group interview B. Lines 54-57.
2.There was a general consensus that they all had religious faith; then one lady said that those that don't have faith get depressed. They feel they are alone/cannot share with anyone and it is only those that recognise that God is present who can feel comfort. This was agreed by everyone. The man also said that you must have faith to get on in life … The lady next to me pointed out that faith didn't heal: it was those that didn't have faith that got depressed … I asked whether this was a Caribbean trait – could they compare British understandings of faith with the homeland? They said immediately it was part of what they have brought with them, something they seemed proud of, that it was part of other beliefs they had brought. Field notes to feedback session i following group interview A. Lines 71-87.
3. I asked whether religion and faith was important to the process of dealing with health problems. There was a consensus about how important it was, and that it had come from the Caribbean. The second man said that it was important in maintaining moral standards too. I did ask whether it was variable between women and men, but they felt that it depended on the individual. Field notes to feedback session ii following group interview A. Lines 71-76.
4. They talked about the fact that faith/church was routine when younger, but that faith had grown with age and offered hope that things will get better. They said that in their generation people 'left it to God. They contrasted this with the younger generation's tendency to take things in their own hands. They felt that this attitude was what was causing younger one's problems – they wouldn't take racism, wouldn't walk away because they expected more rights for themselves compared with their generation who were more accepting. Field notes to feedback session following group interview B. Lines 64-71.

This gender difference may also be explained by the loss of faith among older African-Caribbean men that is referred to in group interview A. Informants here suggest that African-Caribbean men *"feel that God hasn't done anything for them, so their faith has gone"* (see extract below). This might be a consequence of the hostility of British churches to arriving African-Caribbeans during the 1950s and 1960s that is discussed by Denzil in the above section.

Interviewer: Do you notice the difference between men and women as well, do men and women equally go to church the same amount of times=
Emma: =Yeah, some of them.
Cathy: Some. Some. Not all.
Diane: Men don't like women in church!
Cathy: NO! [laughs] Men don't like the church.
Diane: Women make up the Caribbean church anyway.

Interviewer: Do they still have the faith? Or they just don't go to church?
Cathy: They stop believing. They feel that God hasn't done anything for them, so their faith has gone. So rather than go in the church as they say, be hypocrites, they rather stay out and go round to whatever they feel like going around to do.
Group interview A. Lines 655-666.

Other informant's discussion also suggests this, stating that *"there were lots of experiences of racist ministers/congregations ...this meant that some people gave up their faith, although many turned to Pentecostal churches whose teachings are similar to what had had at home"* (field-notes to feedback session following group interview B. lines 58-62).

It might also be that Cathy represents herself in this way partly because living in a Christian way is valued. This is explicit when she states that *"whether you is Christian or not, you must pray"* (see extract 2, table 6.6). Her comments in group interview A also illustrate this (see section 4.4.a, chapter 4). Therefore, her discussion of seeking guidance is also part of the 'discourse of identity and belonging' strategy. As with Denzil's account, Cathy's illustrates the use of resources that inform several different strategies.

6.2.c. Bruce.

Like Denzil, Bruce's discourse enables us to examine how he has negotiated racialised power relationships. Like Denzil, Bruce uses strategies of 'active resistance' and 'discourses of identity and belonging' to mediate aspects of social position that might have health effects. Bruce's discussion of 'active resistance' strategies centres on his involvement in community work with younger people. The resources 'Caribbean identity' and 'Black resistance' inform this strategy. 'Discourses of identity and belonging' as a strategy also draw on understandings of Caribbean culture and these are discussed alongside the self-governance discourse. Bruce's account is not dissimilar to that of Denzil's, despite the generation gap. The main difference is the use of self-governance as a significant discourse.

6.2.c.i. Active resistance: working for community change.

In section 5.3 (chapter 5) material from the interview with Bruce illustrates that he was very aware that racism and racial exclusion exists as part of British society, and that he has personal experience of this. The forms of mediation that are part of Bruce's account are largely in relation to this aspect of his life experience. Table 5.8 (chapter 5) records that Bruce has mediated direct experiences of racism in the work place by using an English accent in order to overcome reservations held against him as a black salesman. However, Bruce is more concerned to address the experience of racial, and material disadvantage through his involvement in youth community work. Bruce challenges his experiences of racism by becoming involved in empowering others through his community work. He refers to this most explicitly following the discussion about his racialised experiences as a salesperson: *"the situation is just sad. And that's why I wanted to do youth work so badly, twice, three times a week I might be coming back but I'm going to try to put something positive ... back into the community"* (see extract below).

> **Bruce:** That life is rough, you know, and you've gotta take the rough with the smooth. I'm just glad that I had a really good solid foundation and not everyone has that ... If you have a solid foundation and people encourage you and say listen and give you good advice and stuff, you are going to come very alienated or very agitated of your health. [ ]. No-one's bothering to find out why, and it's quite easy, a bit of psychoanalysis. But not these things – the situation is just sad. And that's why I wanted to do youth work so badly, twice, three times a week I might be coming back but I'm going to try to put something positive, you know?
> **Interviewer:** Something back?
> **Bruce:** Hmm. Back into the community. And I wouldn't just say to myself 'oh I'm just working with blacks.' No, 'cos in Hackney there is a lot of white kids here and they're just poor ... So their experiences will be very similar, very similar.
> Lines 506-535.

In section 6.2.a I discussed the creation of 'partner' schemes as a means to negotiate the marginalised position of the Caribbean community, which acted to create an alternative within an exclusionary system. Involvement in community group work might be perceived to be a more direct way of addressing exclusion. This work not only addresses disadvantage in its wider context, but may offer those actively involved a sense of self-worth through the process of helping others. This was not explicitly stated by Bruce, but Francise's comments do express this. Field-notes record that she felt her

community work *"was about empowering others and that was uplifting for her and provided a buffer for all the other things"* (see extract below).

> They mentioned another age dimension – that they, at middle-age could accept the attitudes they faced from other people and often made choices to avoid them, whereas younger people attempt to confront attitudes which can create a lot of frustration. Dorothy for example, said that she had made a choice to avoid working in an environment where there was a no-win situation; avoiding the little comments and assumption of a chip on the shoulder. She found this kind of environment 'soul-destroying' and chose not to be part of it for her own 'sanity.' Choosing to opt out was thought by all to be important in itself as it gave a sense of control and power. Lastly, Francise noted that it was different in different jobs: her own was about empowering others and that was uplifting for her and provided a buffer for all the other things.
> Feed back session ii, following group interview E. Lines 46-59.

Other informants comment on the importance of informal community support from Caribbean people. Younger informant Graham states that *"without the Caribbean people I would be nothing <u>really</u>, you know. That's what keeps me going, <u>really</u>, you know?"* (from transcript to interview, lines 160-162). Middle-aged informant, Dorothy, also values the idea of support within the black community. She states that *"I don't think I would like to think that there is any black person out there who would not know another black person who possibly they could talk to on the phone, or who they could call"* (transcript to group interview Eii, lines 821-823).

Comments in the same feedback session illustrate that there might be a life-course difference to the way that the effects of racism are mediated. This appears to reflect the differences in the way that discussion of racism differs across the life-course too (see section 5.3, chapter 5). Informants are recorded as saying that *"younger people attempt to confront attitudes which can create a lot of frustration."* This was also noted by informants in another feedback session, who contrasted this with the tendency among older African-Caribbeans to *"'[leave] it to God.'"* They suggested that the younger generation *"wouldn't walk away because they expected more rights for themselves compared with their generation who were more accepting"* (feedback session i, following group interview B, lines 64-71).

James (1993) comments on the different strategies of coping with racial abuse among different generations. He suggests that 'first' and 'second' generation African-

Caribbeans in Britain do have different ways of addressing racism, and that this reflects their different experiences of racism and their consciousness of a collective 'community'. He argues that the opposition of younger African-Caribbeans is "more instantaneous and more forthright" (James 1993: 251) than those who arrived in Britain from the Caribbean islands. I would argue that findings in this study, discussed in chapter 5, and Krieger's findings (1990) that tolerance and silence typifies the discourses around racism that were constructed by older informants may be borne of the need to be self-sufficient in the face of experiences of racism (see chapter 4). Caribbean Christian teachings, valued by many older informants in this study, might also encourage the development of such a strategy to deal with conflict.

The 'active resistance' strategy of community work then, may reflect the ideologies that have influenced Bruce's generation. In particular, these ideologies may have encouraged Bruce to address racialised disadvantage more directly than older generations, and to give him the understanding that it is within his rights to do so. However, other younger informants address racism in a more confrontational manner, and this will be addressed in section 6.2.d.

6.2.c.ii. Discourses of identity and belonging: Caribbean ways, strength and martial arts.

Bruce's strategy to mediate social circumstances through community work indicates that he may interpret experiences within a community level framework, rather than just at an individual level. The importance of community may also be indicated in his use of discourses of belonging that centre on his sense of belonging to the Caribbean community.

Bruce expressed his sense of connection to the Caribbean strongly throughout his interview. When I asked him if he saw Jamaica as his home he confirms this emphatically: *"Yes, I see it as my home, I see it as my home. I agree with one thing that Margaret Thatcher said 'you're from where your father's from, you're not English.'"* (extract 1, table 6.8). This is particularly significant because Bruce was born in England. He suggests that the strength of his connection to Jamaica may be due to his

upbringing in this country, which gave him a 'background' to Jamaica that was *"very strong"* (extract 2, table 6.8).

Table 6.8. Bruce: connections to Jamaican and Caribbean identity.

1. Interviewer: Do you go home much – do you see Jamaica as your home?
Bruce: Yes, I see it as my home, I see it as my home. I agree with one thing that Margaret Thatcher said 'you're from where your father's from, you're not English.' Maggie, thank you very much! [laughs]
Lines 622-625.

2. Because when you are growing up, very West Indian, very strong, my Jamaica background, very strong. So I suppose as it goes, and if I have children and they grow up they may not have such close links with Jamaica. They may see themselves as more Britain, here, London, kinda style, street style.
Lines 340-346.

3. Bruce: When I was growing up, '70s, when I was allowed on the streets, even right up to my school days, early '80s, community spirit was there, cause we were the first generation of blacks in the country, so we had everything from the Caribbean, even, all the islands had similar things. You respect your elders. If I was walking down the street and I didn't know you from Adam, and if you were an elder person to me, I would turn and say 'good morning' or 'good evening.' I didn't know you, but that's the way we were brought up, to show respect … Anybody could discipline you in the street. If I were throwing stones, a woman could clap me round the head and say [uses Caribbean accent] 'what ya doing boy?' And even if I didn't know it, I'd done something wrong, I'd go home.
Interviewer: Are those very Caribbean things?
Bruce: Yeah, very, but over the years I seen it been watered, watered, watered down. Being here we've picked up a lot of British ways, the discipline has gone, not allowed to smack kids can swear blind, kids have more rights than adults!
Lines 243-258.

4. Bruce: I think Maggie Thatcher helped put it on [the younger generation's] head, you know? Every man for himself, we used to call them 'Thatcher babies!' [laughs] VERY selfish, very selfish! We go on trips, and a kid will have a packet of biscuits. And he may just give his best friend. He's not giving to the others! In my day if we had – my mum taught us this. We have one banana, and there's ten people you break ten pieces, and everybody take a piece. All those kind of ideas, you must share, always look out. I was the second youngest. And my mum always said 'always look out for your brother.' And they did – always look out for me. Always. Not just fisticuffs, 'what's the matter' you know what I mean? That kind of sharing attitude. And I suppose that's a Christian thing as well, you look and see what your neighbour's got. They haven't got none lets give thanks to God and lets share it. That's gone. You ain't got nothing, tough! It's me, me, I am number ONE. Got entrepreneurs here!
Lines 436-451.

Jenny, another young informant, expressed a similar 'background' to Bruce (see extract below). Significantly, Bruce and Jenny both use the word 'strong' several times to describe their 'background' which seems to reflect their sense of being 'grounded'

people. This argument is supported by Bruce's comment that *"I'm just glad that I had a really good solid foundation"* (see first extract in section 6.2.c.i). However, it may also be the case that references to strength also reflect discourses of function, particularly where these are mediated by understandings of masculinity. Bruce may then, be also using this discourse as a resource to represent himself according to masculine characteristics.

Interviewer: Do you feel very much part of that Caribbean culture=
Jenny: Yeah, yeah, I do.
Interviewer: Is that because of your parents, are they quite strong in their ()?
Jenny: Yeah, my grandparents and my parents they're very strong. And my aunts. I've got a lot of family around me, my aunts, so..
Lines 52-56.

Developing such a 'background' of identity has, Bruce feels, *"been watered, watered, watered down. Being here we've picked up a lot of British ways, the discipline has gone"* (extract 3, table 6.8). His discourse begins to introduce a similar moral juxtaposition to that used by Denzil. Interwoven with Bruce's discussion of Caribbean ways are his views on the emergence of what he perceives to be values endorsed during the Thatcher period in office. He discusses the effects that he feels that these values are having on the younger generation with whom he works: *"I think Maggie Thatcher helped put it on [the younger generation's] head, you know? Every man for himself, we used to call them 'Thatcher babies!' [laughs] VERY selfish, very selfish!"* (extract 4, table 6.8). His emphasis of the selfishness of this younger generation, and their every-man-for-himself attitude, implies that there might be a moral tone to these statements, particularly as he juxtaposes this attitude with Christian teachings to share in the same extract. The empowerment derived from a sense of belonging to the Caribbean is reinforced by representing oneself as part of a more moral community too.

Juxtaposing in Bruce's accounts does not seem to be an act of resistance in the same way as in Denzil's narrative. Bruce's comments seem to be more observational, and they convey a sense of the cultural knowledge that is being lost, which other informants also observe. However, where Denzil and other older informants noted the loss, they stated that they were prepared for it in their move from the Caribbean to Britain. However, Bruce and Jenny are not so accepting of this, expressing a sense of sadness

that young African-Caribbeans are beginning to lose their 'background.' Bruce implies that without this people become alienated (see first extract, section 6.2.c).

Bruce discussed the way in which Caribbean and Chinese medicine was taken up as a conscious rejection of Western ways and racial prejudice. He states that this rejection was influenced by the Black Power movement in USA: *"when I was younger, I went through this kinda rebellious stage, started learning about Malcolm X, Martin Luther King, very upset then, how can people treat me like this? So I just thought, I ain't taking nothing from the West"* (extract 1, table 6.9). This supports the above suggestion that different generations may be influenced by different political ideologies. Turning to alternative health remedies such as Caribbean medicines forms both an indirect 'active resistance' strategy and provides a resource for a 'discourse of identity' strategy. Influencing these strategies is a further resource, his teachings in martial arts and the use of Chinese medicine.

> **Bruce:** In the past when I was younger, I went through this kinda rebellious stage, started learning about Malcolm X, Martin Luther King, very upset then, how can people treat me like this? So I just thought, I ain't taking nothing from the West. Even though I can't stand that [medicine], even though I can't stand that aloe vera, can't stand comfrey, whilst I'm when I'm doing the martial arts I thought lovely Chinese people here … I think even now with martial arts recovery and training in martial arts, ylang ylang, all these different names this is meant to be good for your heart. Forget lucozade, if this – gosh! What am I drinking here man! Somehow I've become more [] alternative medicine.

Bruce's use of Chinese medicine extends to his involvement in martial arts.[2] He talks at length about the discipline that he has acquired from this and his capacity to use his energy efficiently. Throughout the interview he characterises himself as calm and able to deal with stressful situations which is an expression of this philosophy. However, references to this philosophy and practice may not only represent an active rejection of Western ways, but may also act to represent Bruce as fulfilling masculine character traits such as those of inner strength and having the ability to cope with life circumstances. The emphasis on strength has already been noted above.

---

[2] The choice of this discipline may not be as arbitrary as it might appear. A Chinese medicine practice is sited close to the community group that Bruce attends, and other informants from the same community group (Graham and Harry) also referred to their use of Chinese remedies.

6.2.d. Opal.

Opal's health and illness accounts represent the influence of the self-governance discourse very clearly. Only a few informants exhibit this discourse so well, and significantly one of these is Robert, Opal's brother. This is particularly significant because both have developed their accounts in relation to the death of close family members (see section 4.5.b, chapter 4 for a discussion of Robert's health and illness accounts). Both appear to have reached similar understandings about these incidents, emphasising the element of 'risk' to health that comes through stretching oneself outside of personal limitations, or as Robert termed it, risk through not pacing oneself. Therefore, both informants have developed strategies that minimise this element of 'risk' as far as possible, and have used the self-governance discourse as a resource. As a result Opal's discussion is fairly singular, and her strategies draw mainly on this discourse, although religious faith is also a significant resource.

6.2.d.i. Active resistance: confrontation and role rejection.

Life-course differences in response to experiences of racism were discussed in the previous section, and it was suggested that younger African-Caribbeans were more confrontational in addressing these actions. This is borne out in Opal's narrative. She states that when *"I find people are being offensive then I just tell 'em. 'Cos it don't go like that"* (see extract below).

> **Interviewer:** Was that, since you left school have you experienced any kind of racism, whether it's really subtle or more institutional or..
> **Opal:** Er, yea::h, I think you come across people and it's subtle. I've just got to the point where I think that most of it's because people just don't know better … I [loudly] for me personally, I don't take that on in an unhealthy way. I just () you can either do what you know, if a man don't know better he can't do better. So if I find people are being offensive then I just tell 'em. 'Cos it don't go like that.
> **Interviewer:** That's how you deal with it?
> **Opal:** Yeah. 'Cos if someone is doing something and they think this is fine to do that the only way they going to find out that it's not fine to do is for you to say something.
> Lines 418-441.

Other younger informants also address racism in a direct manner. Graham states that *"if I go down the street and someone call me a black whatever, I would say something"* (from transcript, lines 115-117). Harry refers to the legal aid that he has sought in

response to Hackney council's inactivity over housing allocation which, he speculates, may be related to racism (see extract below).

> **Interviewer:** And do you think racism is involved in that?
> **Harry:** It could be, I wouldn't really like to play the race card, but I mean, really, I've got [] points with Hackney council, and REALLY to me, that warrants, all right they're telling me I'm a priority with my health, but I've had to go and get a solicitor, to really kick Hackney up the backside, to kick-start them into doing something. I shouldn't have to do that really.
> Lines 81-98.

These responses do seem to reflect an understanding that individuals have the right to be treated equally and with respect, and that they are willing to voice that opinion. This contrasts to the responses noted in the previous section, which argued that older and middle-aged informants were more likely to use strategies that were more community oriented. Some middle-aged and older informants did discuss more individualised strategies, but these involved forms of withdrawal as a means of protest, rather than actual confrontation as noted in the accounts of Opal, Graham and Harry above. These forms of withdrawal ranged from Brandy's discussion of her withdrawal from workplaces that practised racial discrimination:

> **Brandy:** Therefore when someone does not pay the rate that they would give to, let's say a person of another race, I think, 'right, they are the ones in control, they do not pay me, right? Then I go to another workplace.'
> Lines 565-589.

.

to Dorothy's "little protests" which involved withdrawing her custom following racialised comments made to her:

> **Dorothy:** I'm the type who if I go into that [shop] and they ask me a daft question I will not spend my money. I'll come out like, one stage I didn't spend my money in [well-known store] for about 16 years on a principle, or something like that! Until I really had to go and get something, so I went in there [laughs] you know, but I will do things like that. Somebody in a mini-cab office upset me the other night and I phoned him, and I will not use the mini-cab place again! So I do things like that … they might be little protests but I feel, you know, justified in doing that, like so, it's not so much the institutional racism I feel that 99.9 percent of the time I can't do anything about it so I'm not going to get no sleepless night over it, but the little things that I feel effect my day-to-day existence or whatever, yes those things annoy me.
> Group interview Ei. Lines 522-537.

to one informants small act of retaliation after experiencing racialised treatment from a co-worker:

> Informants mentioned that ethnic minorities were disadvantaged in England, which created health problems. This discussion again lead to emotional responses. For example there was a story about one of the women who worked in a hospital kitchen during her first years here. She got on well with her white co-worker but found that the same colleague ignored her outside of the work place, 'shamed' in front of other whites to know a black person. The informant … let the white person suffer in the snow after falling over, being the only person who could alert help. Eventually she did alert someone, and the white person always acknowledged her after that.
> Preliminary discussion to group interview A. Lines 20-27.

The extracts in table 6.9 illustrate another strategy that Opal refers to in her interview, that of role rejection. Her rejection of various roles and the expectations they create, such as those imposed by a peer group (extract 1) or work-related expectations (extract 2 and 3) are in direct relation to her understandings about risk minimisation. For example, Opal explains that her rejection of the lifestyle of her circle of friends, when she was a *"right drunkard,"* was because she felt she needed to *"think about what you're doing to your body. And you see someone who you're really really close to drop dead at 28 for no other reason but for unhealthy living, you gotta come to your senses"* (extract 1, table 6.9). In a similar way, Opal describes her caution about how much of her time is spent in the work-place. She states that *"I'm not really being funny but most work is about is not really a contract. It's a bit one-sided. It's mostly about how much they can take from you"* (extract 2, table 6.9). She expresses particular concern over her emotional well-being in the *"emotionally taxing"* environment in which she works. The risk that she perceives this posing to her health, has prompted her to decide to work with an agency to gain more control over her working hours. Opal then, appears to have fully incorporated the ideas of self-governance into her approach to life, squeezing out risk where she perceives it to be, as a preventative strategy.

Table 6.9. Opal: role rejection

1. Opal: It's like for me, my lifestyle before I made up my mind to be a practising Christian I was a right drunkard, you know what I mean? And a lot of my friends took it hard. To see that I was sobering up and becoming more conscious and whatever. Because if a group of you in the same mess and all of a sudden one has the light come on, sometimes people take it as a reflection on them. But I wasn't doing it for nobody but myself! I was thinking 'no man, I want to look after myself.' I mean I'm not going to do things that are deliberately going to, I'm not saying that you can't have a drink you know, but I think you need to think about what you're doing to your body. And you see someone who you're really really close to drop dead at 28 for no other reason but for unhealthy living, you gotta come to your senses ... People always want you to conform to what they want. But if it's not what you want don't do it! You've got to do what you want because at the end of the day that's the only way you're gonna be happy. If your whole life is gonna be what your employer wants, what your mum wants, what your dad wants, what your community, what your culture wants, what Joe Bloggs wants, what your church wants, whatever. You got to be doing things for yourself.
Lines 465-487.

2. Opal: I'm a mental health support worker as well, and I used to work quite hard and quite long hours and it's emotionally taxing because you're dealing with people's problems and whatever. And I got to the point where I realised it was good to be in that environment … but at the same time, if I'm going to be in that environment, giving, to other people all this time, energy and emotion, then how I look after myself is very important. So at the time I was working full-time and then at the end of [the year] I decided I'm not going to work full-time. I'd go on the agency so that I've got more control over my working hours … Because I really believe right, if you put into yourself good, things that you enjoy, things that make you feel good, things that are good, then what's going to come out of you is going to be good. But if it's just taking, all your life is about somebody taking something from you, and you're not giving yourself any time to replenish and whatever it's not healthy … I think it's important that people have control over their work life because, I'm not really being funny but most work is about is not really a contract. It's a bit one-sided. It's mostly about how much they can take from you.
Lines 143-169.

3. Opal: So I thought to myself 'no, no don't really want to be a slave to work' … As long as I've got enough money to pay the bills so I don't have to you know, have that worry on my mind. I try to avoid worry because that's not healthy. And erm=
Interviewer: =Do you worry very much, now that you've got that control?
Opal: No I don't worry. But that's a <u>decision</u> I made not to worry. I could worry!
Interviewer: Did you worry before?
Opal: Nah, because when I came to the decision it was kind of a planned thing 'this is what I'm going to do.' … It's not that I couldn't worry. There are times when I can say, 'oh yeah', I could worry. But then I realise that for <u>me</u>, worrying is a bit of a helpless state. And it's not getting done what needs to be done. So yeah, I could worry, yeah I could sit down and feel sorry for myself, I could say 'woe is me' but I mean at the end of the day I'm still going to have to get up and deal with it.
Interviewer: Would that apply to things like being anxious as well? You don't need to get anxious about things?
Opal: No I don't, it might sound cold and calculating but I think at the end of the day you got to be real, innit?
Lines 183-205.

Other informants do discuss risk minimisation as a strategy, but only Robert and Brandy discuss it as a wider approach to life. More often, it is discussed as a response to challenging circumstances. Women in particular discuss role rejection in terms of gendered expectations of them in the home and family. Avril's interview illustrates this well. In a discussion with Francise (see extract below) she explains the kinds of expectations of her that she has rejected in response to the onset of hypertension. This extract suggests that she perceives 'worry' to be a risk, as most of her strategies involve rejection of worrying about the family and completing domestic chores. She states that

"there's things you shouldn't worry about, there's things you should let go."

Interviewer: You mentioned about her family, but she decided that she was going to control it a bit more. But does that, you've both [Francise and Avril] talked about work pressures=
Avril: =No. I refuse. I totally refuse. I've become, what's the word? I've become ignorant. And I've said no ... You worry about [the family] when you don't see them, you worry about them when you do see them and they're fine. Erm, taking on other people's concern sometimes is not necessary. Even if you've forgotten to hang your clothes on the line, they're not going to get up and walk away! There's things you shouldn't worry about, there's things you should let go. You know. A phone bill – they can only cut it off. There's a phone box down the road.
Francise: Well, yes your right. For example how I'm going to – the action that I have taken is to make contact with counsellors because I really need someone to talk to. In terms of the anxiety about me not being well. It's there, and I'm worrying and it's not helping the situation. And on top of that there's my brother. So I need also some coping skills, on how to deal with him.
Lines 181-197.

Francise's response to Avril suggest that the ability to centre decisions around one's own well-being and reject social expectations is valued. However, her comments also show that not all informants were able to challenge their roles in the same way, as she still feels a responsibility to provide support for her brother (see also discussion in section 5.2.a, chapter 5). Francise was, however, able to remove herself from the workplace. This, she goes on to suggest, has given her the ability to make other choices about her working life: *"despite the fact that they were quite busy and there were people off I just say no, and I just took the week off from work. And I'm feeling good for it because I then now know that I need to sort out the work situation"* (from interview transcript, lines 145-152).

Whether such strategies are in response to illness or part of a wider approach to risk minimisation in life, they may be empowering because they boost a sense of self-worth because 'self' has been prioritised.

6.2.d.ii. Discourses of identity and belonging: self-governance.

This strategy is reflected in Opal's representation of herself as someone who is in control of her life, and able to cope with problems as they arise. Unlike other informants discussed in this chapter, Opal does not connect experiences of disadvantage or challenges such as racism to her social position, or refer to them as part of a collective experience. Instead, she talks about the experiences that might pose risks to her mental and physical well-being as something that she personally can overcome through a combination of will-power and taking control over her life circumstances. For example, when she discusses her response to racist attitudes (see first extract in section 6.2.d.i) she emphasises that she does not *"take that on in an unhealthy way,"* suggesting that she is able to control the way such comments affect her through her attitude. Robert expresses a similar understanding. Also discussing racism, he states that *"to me I don't actually acknowledge racism, and it's not ignorance. It's a case of understanding people's levels and where they're at ... and if I start taking that on board then eventually I'm going to have to start to address it"* (see extract below).

> **Robert:** And in my later life I haven't really, I don't, to me I don't actually acknowledge racism, and it's not ignorance. It's a case of understanding people's levels and where they're at. Someone might dislike me, they might despise me and they might even want to see my life. But that's because of the level they're at. And again it's basically by what's happened in their past and its things that they have to address. And if I start taking that on board then eventually I'm going to have to start to address it because I'm now trying to say 'well, maybe that's a part of me, maybe it's something to do with me.' And as I said as long as I know that I'm not doing something deliberately to offend someone then I know that I'm okay at the stage that I'm at. I've been able to deal with that.
> Lines 656-665.

This strategy appears to be transferable to a wide range of circumstances. It appears that as long as an individual has the 'correct' mental attitude then they can overcome most situations. This is illustrated in Opal's views about poverty, for instance, in the extract below. She suggests that *"the way the system is [in Britain], if you make up your mind you can get out [of poverty]."*

> **Opal:** Because poverty in this country, there are ways to get out of it. Some people unfortunately there ain't, in other countries. But the way the system is over here, if you make up your mind you can get out. Especially as a second generation, even if your parents lived in poverty, you the second generation, much more opportunity to get out.
> Lines 832-839.

Representing herself as successfully accomplishing the right mental attitude, may provide Opal with a sense of self-esteem. This may be reinforced the representation of herself as religious too. Opal's discourse of self-governance compliments her understanding that God is 'on her side.' This may give her a sense of power, reflected in her statement that *"I can't lose!"* (see extract below) and the faith to be herself, which compliments the value of living life centred around the 'self.'

> **Opal:** And that's where I come from, 'cos I basically realised well, if God's on my side and he created the universe I can't lose! That's how I view life! 'Cos it's like, I got the best in my corner so the best is coming out. So that's how I deal with life. And that doesn't mean I have to go out there and take anything away from anybody. That just means I'm gonna be who I am … And it means that I don't have to let people take away from me. People have their own opinion. It's just their opinion.
> Lines 781-789.

6.3. Conclusions.

Evidence presented in this chapter illustrates clearly that individual's can resistance life circumstances in many ways. The forms of counter-power that informants use in their narratives support Pile's (1997) interpretation of resistance not as fixed in opposition to oppressive powers, but to be read when and where it occurs. Much of the resources used to inform strategies of resistance were centred on discourse, particularly that concerned with representing the self. Therefore the forms of resistance and mediation outlined here are quite specific to the research context. Informants have utilised the opportunity to mediate situations that they are faced with in a spontaneous manner. This suggests that forms of counter-power are not always pre-meditated and, therefore, not necessarily conscious acts of resistance.

Of interest are the kinds of resources used by informants to mediate situations. Often these draw on cultures that are part of their daily lives, such as cultures of masculinity, 'Caribbean culture,' and mainstream cultures such as self-governance. However, although these are resources that are accessible to many individuals in similar situations,

informants emphasised different aspects of resources and combined them with other resources, making their strategies entirely personal. The spontaneous nature of their construction may mean that they are specific to time (of interview) too, and may not be used again in quite the same way. This suggests that acts of empowerment, may often be momentary too, so that power is taken but not held.

If forms of resistance can be specific to the research interview, it is likely that they might in part reflect the nature of the research relationship that has developed. Where informants feel guarded I would argue that strategies are not discussed explicitly, but are *demonstrated* through informants negotiation of the research power relationship. This may be quite explicit by withdrawal of access, but representations of oneself as moral and self-governing may also be a means to mediate power by attempting to monitor the impression of the informant that the researcher takes with them. The influence of the research relationship then, needs to be considered when interpreting discourses of resistance.

7. CONCLUSIONS AND RECOMMENDATIONS.

7.1. A summary of the research and main findings.

The aim of this research has been to explore whether African-Caribbean women and men in east London perceive that their gender social position affects their experiences of health and illness. I have argued that gender position cannot be studied in isolation from other social positions and have consequently sought to understand, in the context of the research question, the experience of gender as it is mediated by other factors such as 'race' position, stage of life-course and socio-economic status. The methodology developed for this study has been influenced by concerns with the social distance between researcher and researched, particularly the different 'race' positions both occupy, and the appropriate representation of a marginalised population group. Therefore a significant focus of the methodology has been to seek to 'even out' the social distance between researcher and researched to some degree. This has involved the use of strategies such as: taking a 'supplicant' position, spending time with informants outside formal interviews, ensuring participants willingness to be involved in the project and their inclusion in validating interpretations of material through feedback sessions. Another part of this strategy has been the use of unstructured group and in-depth interviews to explore the perceptions of informants. Informants were also asked to complete and discuss their views on question items of a health 'questionnaire' which was put together for this project. To capture individuals who identified with the category 'African-Caribbean,' community groups providing services to the African-Caribbean population in east London were used as a means to approach participants in this study.

Overall, findings from this study show that *gender is linked to experiences of health and illness*, and that this relationship is mediated by other aspects of social position. In chapter 4 the way in which informants talked about their health and illness experiences was examined closely. Findings suggest that individuals use a variety of different 'accounts' to describe and explain their health status and that the construction of these

accounts is significantly influenced by social location and the research context. Where informants were discussing health and illness experiences in a group, and where the researcher was little known to them or accepted by them somewhat reservedly, informants discussed predominantly 'public,' or socially sanctioned, accounts. Where informants felt able to discuss their health and illness experiences more openly they used private, or more personal, accounts. Among the discourses influencing public accounts the more pervasive were medical and moral in nature. Medical discourse was characterised by the prioritisation of a medicalised understanding of health and illness. Moral discourse reflected a concern to behave in a responsible manner towards preventing, acting on and coping with ill health. Moral discourse had two different sources of influence: Christian church teachings and the rhetoric of self-governance which places responsibility for health prevention with the individual, particularly through adherence to a Health Promotion prescribed lifestyle.

Public accounts were also influenced by the expression of gendered identities. Women expressed their emotional strength by emphasising their ability to cope with ill health, by adopting a stoic attitude, whilst men expressed their physical and emotional robustness either by presenting accounts of themselves as free from health problems, or by minimising the problem and discussing it with jollity. Gender differences in discussing health and illness were pronounced among informants aged over 50 years, suggesting that more traditional understandings of gender identity and social roles contribute to the ways in which these informants present their health status. Besides the gendered nature of understandings of functioning and strength, it may also be that these reflect experiences of hardship and racialised disadvantage where informant have had to develop strategies to cope with their economic and social circumstances.

Gender differences were also found in the dynamic nature of discussions about health and illness experiences. Women were much more likely to discuss a wider variety of accounts, particularly during in-depth interviews, of both public and private categories. Male informants were much less likely to do this, often continuing to discuss a more limited range of public accounts only. This may reflect the fact that male informants were relatively less comfortable with the researcher compared with female informants. It is also likely that concern to convey a 'masculine' self image, and therefore of robust

health, prevented men from discussing, and maybe even thinking, beyond the boundaries of public accounts.

This chapter also identified a guardedness among mostly older informants in completing the health 'questionnaires' presented to them during group interviews. Reservations about recording information on paper stemmed at least partly from insecurities held as a result of experiences of racism, including racism among health professionals. It was assumed that these reservations also had some affect on the discussions held during interviews, perhaps providing a further explanation for the use of public accounts among older, rather than younger, informants.

Chapter 5 focuses on the connections informants themselves made between experiences of health and illness and social location. Clear gender differences emerged in the way gender social role and expectations were thought to influence health and illness. With the exception of Harry, male informants made no connection at all between gender and ill health. Female informants however, perceived strong connections, particularly with regard to care and marital roles they felt expected to fulfil, and some informants explained how health problems emerged when their ability to fulfil these roles was impaired. The connection between gender and health was made predominantly by older female informants and I have suggested that this may be linked to the greater value placed on traditional gender roles by older informants in general, so that for women roles viewed as 'feminine,' such as those connected to the home and family, are more salient. Younger women in this study do not place the same value on these roles, valuing also work and career roles. Valuing a wider range of roles may act to protect younger informants from health problems as challenge to one salient role may be compensated by success in another.

Older male informants appear to value roles understood to be 'masculine,' particularly those holding men responsible for supporting their family financially. Very few of the older men in this study have had this 'breadwinner' role challenged and have been in paid employment all their working lives, explaining to some extent why male informants did not discuss gendered experiences as a 'risk' to health. The one male informant who did make a connection between gender and health discussed his sense of frustration in not achieving this role of salience to him. The fact that little connection between gender and

health was made by male informants might reflect a further influence of their perception of a socially constructed 'masculine' self image.

Other evidence presented in chapter 5 suggests that racialised experiences are also perceived by many informants to be a potential health 'risk.' These experiences are discussed both through personal experiences of racism and discrimination, often in the work-place, and as a collective experience of institutional racism from welfare services and the police force in particular. However, although informants point to the *potential* risk to health from these experiences, all clearly stated that they have not let personal experiences of this affect their health, and have often developed specific strategies to combat the experience.

Further connections between health and social location were limited, although economic hardship and poor living conditions were discussed as health risks. I have suggested however, that this may not have been because other aspects of social position are not perceived as risks to health, but might instead have been a result of the agenda of both the researcher and some of the researched during interviews. This study has been conducted with sensitivity to racialised relations, both in the research relationships and in society in general. Therefore, with hindsight it is clear that priority was given during interviews to 'race' issues. Parallel to this it is likely that the more politically aware informants have seen this project as a means to express their feelings regarding treatment of black people by statutory organisations in their locality. The outcome then, has been a focus on gendered and racialised experiences as potential risks to health, limiting the ability to make conclusive statements about the relationship between all aspects of social location and ill health.

Chapter 6 explores, through the interviews of four informants, the ways in which individuals resist and mediate problematic aspects of social position and subsequent experiences of ill health. Findings cannot be generalised beyond this sample group of informants, and the strategies and resources used to mediate circumstances are specific to individuals. What is important to note however, is that resistance and mediation occur, and that, collectively, these four informant have used a wide range of cultural resources in the process of mediation. Three strategies of mediation were identified: active resistance to circumstances, the use of discourses of identity and belonging, and seeking

guidance. To achieve mediation through these strategies different resources were used. These included ideology of Black resistance, Caribbean culture and Christian faith, as well as discourses that were also noted in 'public' health and illness accounts, such as self-governance, morality and gendered values of strength. The use of strategies and resources is complex. Informants used more than one strategy during interviews, and often multiple strategies were discussed to explain their negotiation of any particular situation. A variety of resources were used to promote a strategy by each informant, and often the same resource was used in different ways to resist or mediate circumstances.

The evidence presented in chapter 6 does not indicate that a clear gender pattern exists in the use of strategies and resources, although female informants appear to use 'seeking guidance' as a strategy more than male informants. Stronger evidence does exist however for a pattern across generation groups. Strategies of older informants reflect more conservative and tolerant ideals, strategies used by younger and middle-aged informants reflect Civil Rights influences, particularly Black Power, whilst informants under 30 years appeared to be influenced by neo-liberal rhetoric, particularly self-governance, more than other age groups. It may be the case that such strategies and resources are invoked specifically by marginalised groups who face exclusion, but this could only be verified by extending similar research to other disadvantaged groups. Another significant finding is that resistance and mediation was contained within the discourse of the interview itself i.e. one strategy of resistance was *through* the interview, using resources of self-representation. Using the opportunity of an interview in this way suggests that resistance and mediation is not always pre-meditated but spontaneous. Consequently, discourse in this context should be interpreted as time-specific as it is likely that the strategies and resources identified in the interviews are used in different forms by individuals in other situations. This finding supports the view that the research context is integral to the construction of interview discourse.

Overall, material in this study shows that gender social position influences the experience of health and illness, and that other aspects of social location mediate this relationship. The relationship between all of these factors is complex and it may be that any one aspect of social location cannot be fully separated from another in this relationship. The study has also shown that research context is important to consider when interpreting health and illness accounts. Material here suggests that interview discourse reflects to some degree

the relationship between researcher and researched, and the opportunities that the interview represents to informants. Section 7.2 outlines some of the main contributions that these findings make to theoretical and methodological discussions. Section 7.3 assesses some of the current government policy initiatives in health care and prevention, both at statutory and the local level, and outlines recommendations for implementing these policies in light of these findings.

7.2. Developments and contributions to present debates.

7.2.a Health and illness accounts

Findings in this study advance discussion about health and illness accounts in several ways. Firstly, it was clear that gender differences did exist in the way that informants discussed their health and illness experiences, and that this difference reflected gender ideologies. Traditional understandings of women's and men's social roles appeared to be reflected in the value placed on how an individual presents themself in relation to health and illness, as discussed above. In addition, there is evidence that gender ideologies are changing for women, as younger women's discourses in this study bear closer resemblance to presentations of self as able to resist the effects of difficult circumstance noted among male informants rather than the presentation of oneself as stoic.

Secondly, there is evidence that discourse around health and illness in this study reflects similar influences to those found by Cornwell (1984) in the public accounts produced by her white working class informants in east London. She noted a tendency to use medicalised accounts of ill health, and the same discourse forms part of the interview narratives of older informants in this study. Cornwell also noted that public accounts in her study were influenced by moral values of functioning, and again these are reflected in the accounts of older informants in this study, although I have noted that ideas of function are gendered and women and men produce these accounts in different ways (see above). The similarities between Cornwell's public accounts and those discussed in this study suggest that there may be a class dimension to these accounts. This cannot be categorically stated, but it is the case that informants in this study who produced similar

accounts to Cornwell's working class informants were also engaged in low status employment during their working lives.

There are aspects of moral discourse which influenced public accounts in this study which were not noted by Cornwell. Having an active Christian faith and belief in God were an important part of self-representation for older informants in discussions relating to health and illness, particularly among women. This aspect of moral discourse reflects the value placed by older informants in what they perceived as an aspect of Caribbean culture. This element of public accounts then, was seen to be specific to African-Caribbeans groups, and in particular those who were brought up in the Caribbean. Another aspect of moral discourse that was identified in this study reflects the rhetoric of self-governance, which emphasises an individual's responsibility in promoting health through lifestyle. This is a contemporary rhetoric that may not have been as popularised at the time of Cornwell's study compared with the late 1990s when this study was conducted. The contemporary nature of this rhetoric is reflected in the fact that it is noted mostly in younger and middle-aged informant's discourse, and appears therefore, to be generation specific.

Thirdly, it is clear that the research context had some influence on the interview material that was produced in this study. More personalised accounts of health and illness were produced only when informants appeared more at ease, and when they were in a more private setting alone with the interviewer. Account sympatricity (Stainton-Rogers 1991) was also more apparent during these individual interviews. The perception of myself as the researcher and the relationships that informants developed with me also contributed to interview outcomes. In this study I have attributed much of the effect of my position to the difference in 'race' positions between myself and informants. This is supported to a significant degree by the statements of older informants outlining their guardedness in discussing personal health problems with a white person. However, although this was a significant influence, with hindsight it is more likely that the social distance between myself and informants in general, and the association perceived between myself and the medical profession, created boundaries. This is most apparent in the reluctance to record personal information on the health 'questionniare' during group interviews. Reservations were due to prior experiences of racism, which has prompted fears about how health researchers use the information they

gather. This has implications for health research in general and, in particular, practices of ethnic monitoring. It is not clear whether the sensitivity of this study to power relationships, and the subsequent development of research strategies to bridge these dynamics, countered these boundaries to any significant degree, although they did enable me to approach and 'recruit' informants with greater success. However, the unstructured methods used enabled informants to narrate their accounts in their own words, and this is importance in terms of a valid representation of their experiences. It is also hoped that using these strategies enabled informants to feel more like active participants rather than passive objects of study.

7.2.b. Social location and ill health

This study has made important contributions towards understanding the mechanisms involved in women's and men's reporting of ill health. Findings discussed above suggest that part of the explanation for gender differences might lie in the different ways in which women and men, particularly those in older age groups, discuss their health and illness. A further explanation explored in chapter 5 is that women may be exposed to greater health problems than men due to their relative positions in gendered social relations. The expectation of women to provide emotional support and care for the family and partner vis-à-vis the expectation of men to provide economic support to the family through contributions from waged work, appear to be key to understanding why women might experience greater health problems than men. Evidence in this study suggests that ill health is perceived by informants when functioning in these gendered roles becomes emotionally challenging (Thoits, 1991), and it is mostly female informants who have found the fulfilment of these roles to be a challenge at some point in their lives. The reasons for this have not been explicitly discussed by informants in this study but it is reasonable to suggest that this might be explained by any of the following: because of difficulties in providing support for several members of the family at the same time; because providing support leaves informants with little time to care for themselves; because the amount of support thought to be appropriate is individually defined by women themselves (and perhaps by the demands of family members), creating difficulties in acknowledging when satisfactory support has been provided; because challenges arise when women's time is demanded by other responsibilities such as waged work; or because the care work that they do is little

valued by society. In contrast men in this study, who do not make reference to feeling emotionally challenged, have been engaged in roles that they have been able to fulfil throughout their working lives, which are socially valued and where the boundaries of time and energy given (to the work-place) are more clear. The exception to this pattern in men's discussion in this study has been during an interview with Harry, who discusses the emotional strain he feels in not being able to fulfil his role in providing financial support to his son, thus supporting the argument made here further.

As noted, younger women in this study do not discuss the same kinds of emotional challenges as older women, and this might be explained by the fact that younger women appear to value their waged work and career roles as much as their roles in providing for a family. It may be that engaging in more socially valued roles, which have clearer boundaries for time and energy, are more protective for emotional health, and where women value both waged work and care roles together it may also be the case that emotional challenge in fulfilling one role may be offset by achievement in another. This explanation goes some way towards understanding inconsistencies across the lifecourse in a gender pattern of health reporting, discussed by Macintyre *et al.* (1996). These findings also raise interesting questions as to the relationship between experience of ill health and the way in which informants conceptualise and discuss health and illness. It was noted in section 7.2.a that the discourses of women under 30 years appeared to be more similar to those of men in many respects than those of older females. Is the fact that these informants are less emotionally challenged by their roles part of the reason why certain accounts of health and illness are adhered to i.e. more public accounts? Does this mean that more idiosyncratic and personalised accounts are only conceptualised when distress and the consequent effects of this on health are faced? I would suggest that these questions cannot be answered without reference to the time-specific nature of the interview. It might be that those women who made connections between their roles and ill health were experiencing problems at the time of the interview, or had done so recently. The fact that some informants did not discuss the same connection may not indicate that they had *never* made such a connection, or had *never* experienced challenges in their gender social roles, but that they had not experienced this near the time of the interview.

A further important finding is the connection that informants made between 'race' position and ill health. This is important for two reasons. Firstly, there was widespread recognition that the consequence of acts of racism and exclusion had potential effects on health. In particular informants discussed the emotional stress and physical ailments that might result from difficulties in obtaining employment among young black men, the racialised allocation of housing and other resources with the result of material and social poverty, and the treatment of young black men by the police force. Suggesting that, contrary to Nazroo's argument (1997a) that evidence of difference in health status between ethnic groups is due mainly to socio-economic status, aspects of 'race' position itself are perceived by informants to have an effect on health that is independent from socio-economic status. Secondly, despite agreement among many informants about the potential effects on health of their 'race' position, none of the informants stated that these experiences had actually had a direct effect on their own health. Besides the obvious conclusion, that informants have not experienced adverse health effects because of these exclusionary practices, I have speculated that this might also be part of a public account used by individuals concerned to represent themselves as able to cope with such racialised practices. It might also be that this issue was difficult for informants to discuss with a white researcher. There is, however, evidence that informants can mediate the effects to some degree, and this is discussed in the section below. There is further evidence then, to suggest that material produced during interviews is influenced to some degree by the research context. I have noted in section 7.1 that the sensitivity of the researcher and the politically aware agendas of some of the informants meant that issues related to 'race' position were prioritised during the interviews. This has had the effect that perceptions of the relationship between health status and other aspects of social location have not been drawn out fully. However, there is enough evidence to suggest that stage of life-course and socio-economic status, and associated experiences of hardship and class culture, are integral factors to the experience of health and illness.

7.2.c. Strategies of mediation and resistance

Further contributions are made in the findings relating to the mediation and resistance of difficult and challenging experiences. Contrary to traditional understandings of the way power is challenged, i.e. through confrontational action, findings here show that informants have challenged their problematic situations through ways that are not

confrontational, corroborating the work collected by Pile and Kieth (1997). In addition, resistance has been expressed through the use of the interview format of this study itself, providing evidence that resistance can also be spontaneous. Also important is the finding that informants in this study have invoked aspects of their marginalised positions in order to transform their experiences – this may be specific to their position as part of a minority ethnic group

There are generation differences in the kinds of strategies of mediation and resistance that informants use, reflecting again the importance of stage of lifecourse in the experience of health and illness. Older and middle-aged informants were more likely to draw on a shared identity of community and culture that represented the margins, either through the use of 'Caribbean' identity or Black identity. In contrast, younger informants were more likely to represent a positive self-image of themselves through discourses that belong to the centre. In particular, informants represented themselves as 'successfully' achieving valued elements of the self-governance rhetoric. This is of particular interest because the emphasis on the individual, both as 'controller' of health status and of life circumstances, acts to *depoliticise* experiences of disadvantage and ill health, compared with the politicisation that occurs in older informants use of discourses representing the margins. The tendency among younger informants to use discourses that emphasise individual agency may explain to some extent why informants aged less than 30 years were less likely to state that structural position influences their health and illness. The use discourses of the centre seems to represent the fragmentation of 'Caribbean' identity among young African-Caribbeans, noted by some of the older informants, and the identification of this younger group with aspects of more mainstream British society following their birth and upbringing in this country. The effects of this fragmentation and experiencing life between cultures of the centre and categorisation as Black, on those aged under 20 years are not fully explored in this study. It may be that the self-governance discourse represents a means for younger African-Caribbeans to develop a sense of belonging to a more individualistic youth culture in Britain, and to develop strategies to protect themselves from difficult experiences. Exploring this further would be a worthy avenue of study.

Lastly, an important finding is that if the research project has created any sense of empowerment for informants at all, it has not been through the unstructured interviews.

These have provided many informants with an opportunity to express their frustrations about the racialised treatment they have experienced and as a means to actively mediate the same experiences by promoting a sense of self-worth. It may be that other aspects of the methodology used facilitated informant's use of the interviews in these ways. emphasising as they did the agency of informants in the research process. In particular, spending time with informants outside of the interview created a sense of trust that was conducive to informants expressing their views, and the use of unstructured interviews was crucial to the development of informant's own narratives. Burgess (1988) also argues that group interviews can be empowering experiences where informants collectively make connections between aspects of their experiences that had perhaps not been thought of before, and this was noted in some of the group interviews in this study. In particular, participants of group interviews Ei and Bi, and of feedback sessions (that were not structured around health 'questionnaires,') appeared to enjoy the discussions and did explore aspects of their own lives that they had not addressed before. However, other strategies in this research have, essentially profited the researcher rather than the researched. In order to engage in research that is truly inclusive and empowering, research has to be conducted in a more participatory way and led by informant's themselves, placing the researcher in an entirely new position vis-à-vis informants. Despite this, I would argue that the methodology used for this research has been appropriate for the study, although attention to power relationships would have been better addressing wider social differences between the researcher and researched rather than differences in 'race' position alone.

7.3. Policy recommendations.

A major focus of this study has been to explore the relationship between structure and agency and their influence on experiences of health and illness. Findings suggest that structural position has a significant impact on these experiences indicating that those in marginalised positions will experience worse health. For those that occupy multiple positions of low status, such as women of minority ethnic status, the health outcomes are potentially worse. Findings of this study show, however, that individuals are often able to negotiate the effects of their position and their ill health to some degree. Although individual's agency do not mitigate the effects of marginalised status

completely, it is clear that processes of counter-power exist which can be built on to promote health. I will argue here that a three-pronged approach to addressing health problems is needed; one which tackles aspects of structural position, one which addresses appropriate service provision to minority ethnic groups in east London, and one which promotes agency and self-determination. Specifically, I would support regeneration strategies which address the poor material and social environment in which many minority ethnic groups live, particularly strategies which are sensitive to the gender and 'race' issues which mediate the lived environment for populations in regenerated areas. Prioritisation of key areas of service provision are also recommended, with some suggestions about mental health services in light of the findings in this study. Lastly, support for community capacity building and a new way of defining agency and it's promotion is recommended.

7.3.a. Regeneration strategies.

Recent government proposals illustrate that measures are being taken to tackle social and economic disadvantage in an attempt to promote better health for all. For example, The white paper, Saving Lives, which was developed from the recommendations of the Acheson Report (1998), discusses how the wider causes of ill health will be approached. Statements are made about action to improve income levels, education, homelessness, risks to health in the work place, initiatives for the long-term unemployed and the healthiness of local neighbourhoods. Statements are also made about taking an integrated approach to improve environments, through the *Health for All* and *Local Agenda 21* initiatives, and to address health inequalities experienced by minority ethnic groups, including racism and racial discrimination. These statements go some way towards the development of inclusive and pervasive strategies of regeneration. The health authority for east London, East London and the City Health Authority (ELCHA), have supported these statements in the development of their regeneration strategies which are outlined in their Health Improvement Programme. In their Annual Report (2000) ELCHA state their commitment to improving education, job opportunities, housing, community facilities and the environment through estate-based regeneration initiatives, with the inclusion of the local Health Action Zone (HAZ) partnership. The HAZ aims to build working relationships between statutory, private and voluntary organisations and to facilitate closer links with the communities that are served. An

earlier Annual Report (1999) states ELCHAs commitment to regeneration with community involvement at the centre, and to develop strategies specifically for targeted areas and populations and to support the community under 'regeneration.'

There are, then, initiatives in place already that offer the potential for transforming the social and material disadvantages discussed by informants in this study at the local level. To promote the commitment to inclusion during the development of regeneration strategies, and to create regeneration for all in the targeted areas, some consideration must be given to the gender and 'race' dimensions of the lives of those in targeted areas (Brownhill and Darke 1998). Strategies of development must reflect the differential access to resources experienced by sections of the community. For example, in this study findings show that there is a perception that access to a variety of resources is racialised, including access to housing, employment, and resources for African-Caribbean community facilities such as community groups. Therefore equality in access to resources needs to be addressed in any regeneration strategy for this area where minority ethnic population groups are numerous. Understanding how disadvantage affects women and men in different ways is important to consider too (May 1997), particularly across the life course. In this study the unemployment of younger male informants was discussed so that creating access to work for this group of young men should be a part of regeneration strategy. Also of concern to many informants was the treatment of young black men by the police. Community relations need to be addressed for regeneration to be entirely successful – this might extend to tackling the racism informants perceived to exist among personnel in welfare and health services. Strategies of regeneration then, need to be informed by an in-depth understanding of the problems faced by the community involved. In addition, achieving full inclusion to debates about regeneration strategies relies on the development of community members' sense of active ownership from the outset of regeneration. A 'bottom-up' approach must be supported, perhaps mediated by the HAZ team. During this research it was noted that a lot of distrust regarding statutory agencies exists within the localities studied in this research, and these reservations are shared by community group co-ordinators. It is, therefore, essential that processes of development are transparent, which will involve putting into place policies and practices that prevent racism and sexism operating during the development process.

7.3.b. Priorities for service provision.

A further strand of ELCHAs commitment to health improvement has been to prioritise specific services for improvement across east London. The services prioritised are: children, younger people, maternity care; heart disease, stroke and diabetes; mental health, drugs and alcohol; older people; and general practice and primary care (ELCHA 2000). The Mental Health priority in particular is of interest in the context of this study as there are strong connections made by informants between their social location and emotional or mental health problems. Findings suggest that a need exists for services which support less severe problems such as anxiety, distress and possibly mild depression, particularly among women. It may be that this need could be met by the greater availability of resources for community groups, which informants already find useful in providing support. It may be that different pathways of support need to be created for women and men. Evidence in this study suggests that women tend to speak more openly about their health problems and that the act of talking about their problems provides a means to deal with them. In fact, some of the female informants commented that they attended their community group for that reason. Therefore, a space in which experiences and feelings about certain issues can be aired and discussed, such as a community group might provide, may be appropriate for women. Men may not benefit from such an approach however, finding, as is suggested in this study, a stigma in making reference to not coping or being perceived to be less than emotionally and mentally robust. It is difficult to make concrete suggestions about how men's mental health might be provided for considering the widespread reluctance to discuss health problems and seek help. One finding of this study is that distress and anxiety appears to be mitigated for men when they are engaged in waged work or roles that help them realise a sense of function. This suggests that supporting men back into work, or in the work-places they already belong to, is a feasible way of providing support. This is reflected too in Acheson's Report which recommends that "policies which improve the opportunities for work and which ameliorate the health consequences of unemployment" (Department of Health. 1998: 126) should be supported for minority ethnic groups. The need to address young black men's unemployment through regeneration strategies then, becomes even more paramount. With these suggestions in mind, it is therefore disappointing that ELCHA's Mental Health prioritisation focuses exclusively on the provision of services for severe mental illness. Clearly this is of

value, although it raises questions as to how far these services should be prioritised to the exclusion of other avenues of preventing mental ill health.

It is worth noting that the monitoring of service use, which is viewed positively in the NHS, has created concerns among informants (referred to in chapter 4) regarding the recording of service users ethnicity. The rationale for this has been to enable a better understanding of the take-up of services by ethnic minority groups in order to tackle inequalities in service provision. However, informants in this study were not convinced of this and showed concern that a racist agenda might exist. The authority invested in medical research, as discussed in chapter 4, may mean that despite such concerns, service users are likely to be compliant in the process of monitoring. Therefore where ethnic monitoring is to be conducted clear explanations need to be given for its conduct along with clear options to decline participation.

7.3.c. Promoting agency and self-determination.

The recommendations made above for the development of regeneration strategies promote the ability for individuals and the community to have a direct input into the ways that their lives might be improved. This kind of support for the development of agency among individuals and communities has been lacking in government directives during the 1980s and early 1990s (Thomas 1999). This is implicit most clearly in the top-down nature of the development of health policy, but also in the reductionist way in which the concept of 'self-determination' is represented in health prevention programmes. 'Self-determination' is widely understood to describe a process in which an individual or group acts in a way to transform, or mediate, any given situation, and is essentially a political act. These processes of counter-power were explored in chapter 6 of this thesis. Subsumed within the rhetoric of self-governance however, 'self-determination' becomes reduced in meaning by the assumption that controlling health status by 'choosing' to lead a 'healthy' lifestyle is an act of empowerment. Clearly it is useful for individuals to have of knowledge about the influence that diet and exercise, among other lifestyle factors, as a resource to draw on to prevent health problems. The concern is that this discourse, which places the onus on the 'self' to minimise risk factors to health, is actually disempowering in it's effect, as choice and decision-making is not placed with the individual but with policy makers and Health Promotion. This

may be exacerbated by the fact that scales of success/failure are emerging which are creating a new kind of social stratification according to who successfully mediates health problems (Nettleton (1997) and Petersen (1997)). As it is those with better access to resources who are able to adhere to a health-promoting lifestyle, existing hierarchies of social stratification will be reinforced. In combination with this, those in marginal positions already, may not want to take up health discourses that represent the centre, but discourses that can be claimed from the margins, as has been shown in the findings of this study.

The current shift in policy towards supporting community-based initiatives and individual's active role in transforming their own situations is, then, to be supported. I would emphasise the need to put in place the recommendations suggested in 7.3.a regarding inclusion and transparency for these proposals to be effective. There also needs to be consistency across service provision and commissioning in order to promote the perception that policy makers are genuine in their approach. For example, the current promotion of community-based initiatives for the regeneration of areas in east London could be compromised by the withdrawal of funding for key community groups in the localities where this study has been conducted.

It seems that policy at the local level in east London is becoming more sensitive to the experiences faced by local population groups in their everyday lives. To develop strategies that reflect the circumstances of this group further, I recommend three avenues for research that have emerged from this project. Firstly, there is much more scope for developing understandings about men's perceptions and experiences of ill health, and for exploring appropriate ways in which health care services can be provided to them. Secondly, it would be useful to explore the role that community groups have in providing a means of support and prevention for mental health problems among women. Lastly, understanding the experiences of younger generations is useful, particularly as a guide to planning long-term service provision that is appropriate to this sector of the population as it ages. Research examining the position of African-Caribbeans in Britain aged under 20 years, as it relates to their experience of ill health, would be one avenue of research that would be useful to east London health service providers.

BIBLIOGRAPHY.

Ahmad, W.I.U. 1993: Making black people sick: 'race', ideology and health Research. In Ahmad, W.I.U. (ed) *'Race' and Health in Contemporary Britain.* Buckingham: Open University Press, 11-33.

Anthias, F. and Yuval-Davis, N. 1992: *Racialised Boundaries: race, nation, gender,* colour and class and the anti-racist struggle. London:Routledge.

Anson, O., Paran, E., Neumann, L., and Chernichowsky, D. 1993: Gender differences in health perceptions and their predictors. *Social Science and Medicine,* 36, 4, 419-27.

Arber, S. 1989: Gender and class inequalities in health: understanding the differentials. In J. Fox (ed) *Health Inequalities in European Countries.* Aldershot: Gower, 250-279.

Arber, S. 1990a: Revealing women's health: re-analysing the General Household Survey. In H. Roberts (ed) *Women's Health Counts*. London: Routledge, 63-92.

Arber, S. 1990b: Opening the 'black box': inequalities in women's health. In P. Abbott and G. Payne (eds) *New Directions in the Sociology of Health.* London: The Falmer Press, 37-56.

Baldwin, E., Longhurst, B., McCracken, S., Ogborn, M. and Smith, G. 1999: *Introducing Cultural Studies.* London: Prentice Hall Europe, 94-95.

Banatvala, N. and Jayaratnam, J. 1996: Equal opportunities for health care? The experience of east London's minority ethnic communities. In East London & the City Health Authority*: East London and the City: Health in the east end: a public health report 1995/96.* London: Public Health Directorate, 20-33.

Bardsley, M. and Hamm, J. 1995: *The health of Londoners project: Londons health key facts and figures. Discussion Paper No.1.* London: Public Health Directorate.

Bartley, M., Popay, J. and Plewis, I. 1992: Domestic conditions, paid employent and women's experience of ill-health. *Sociology of Health and Illness,* 14, 3, 313-343.

Baxter, J. and Eyles, J 1997: Evaluating qualitative research in social geography: establishing 'rigour' in interview analysis. *Transactions of Institute of British Geographers NS,* 22, 505-525.

Bhopal, R. 1995: *Ethnicity, race, health and research: racist, black box, junk or enlightened epidemiology?* Draft of paper to Society for Social Medicine Scientific meeting.

Blakemore, K. and Boneham, M. 1994: *Age, Race and Ethnicity: a comparative approach.* Buckingham: Open University Press.

Blaxter, M. 1989: A comparison of measures of inequality in morbidity. In J. Fox (ed) *Health Inequalities in European Countries*, Aldershot: Gower, 199-230.

Blaxter, M. and Patterson, E. 1982: *Mothers and Daughters: a three generational study of health attitudes and behaviour.* London: Heinemann.

Blaut, J.M. 1992: The theory of cultural racism. *Antipode,* 24, 4, 289-299.

Brownhill, S. and Darke, J. 1998: *'Rich Mix:' inclusive strategies for urban regeneration.* Bristol: Policy Press and Joseph Rowntree Foundation.

Bryan, B., Dadzie, S. and Scafe, S. 1985: *The Heart of the Race: Black Women'sLives in Britain.* London: Virago Press.

Bryman, A. 1988: The debate about quantitative and qualitative research. In *Quantity and Quality in Social Research*, London: Unwin Hyman, 93-109.

Burgess, J. 1996: Focusing on fear: the use of focus groups in a project for the Community Forest Unit, Countryside Commission. *Area,*28, 2 130-135.

Burgess, J., Limb, M. and Harrison, C.M. 1988a: Exploring environmental values through the medium of small groups: 1. Theory and practice. *Environment and Planning A,* 20, 309-326.

Burgess, J., Limb, M. and Harrison, C.M. 1988b: Exploring environmental values through the medium of small groups: 2. Illustrations of a group at work. *Environment and Planning A,* 20, 457-476.

Burgess, J. and Pile, S. 1991: Constrctions of the self: some thoughts on the need for a psychoanalytical perspective. In C. Philo (ed) *New Words, New Worlds: reconceptualising social and cultural geography.* Aberystwyth: Cambrian Printers, 31-32.

Burgess, R.G. 1984: *In the Field: an introduction to field research.* London: Routledge.

Calnan, M. 1987: *Health and Illness: the lay perspective.* London: Tavistock Publications.

Celantano. D., Linet, M. and Stewart, W. 1990: Gender differences in the

experience of headache. *Social Science and Medicine,* 30, 12. 1289-1295.

Clarke, J.N. 1983: Sexism, feminism and medicalism: a decade review of literature on gender and illness. *Sociology of Health and Illness,* 5, 1, 62-82.

Cohen, S. and Wills, T.A. 1985: Stress, social support, and the buffering hypothesis. *Psychological Bulletin,* 98, 2, 310-357.

Cooper, C. 1993: *Noises in the Blood: orality, gender and the 'vulgar' body of Jamaican popular culture.* London: Macmillan Education Limited.

Cornwell, J. 1984: *Hard-Earned lives: accounts of health and illness from east London.* London: Tavistock Publications.

Courteney, W.H. 2000: Constructions of masculinity and their influence on men's well-being: a theory of gender and health. *Social Science and Medicine*, 50, 1385-1401.

Crang, M. *et al.* 1997: Software for qualitative research: 1. Prospects and overview. *Environment and Planning A,* 29, 771-787.

Cruikshank, B. 1993: Revolutions within: self-government and self-esteem. *Economy and Society*, 22, 3, 327-344.

Cruikshank, J. 1989: An outline of cerebrovascular and renal disease. In J. Cruikshank and D.Beevers E*thnic Factors in Health and Disease*. Sevenoaks: Wright, 266-268.

Cruikshank, J. 1993: The challenge for the Afro-Caribbean community of controlling stroke and hypertension. In *North East and North West Thames RHA*, 27-42.

Cruikshank, J. and Beevers, D. 1989: *Ethnic Factors in Health and Disease*. Sevenoaks: Wright.

Curtis, S. and Taket, A. 1996: *Health and Societies: changing perspectives.* London: Arnold.

Curtis, S. and Lawson, K. 2000: Gender, ethnicity and self-reported health: the case of African-Caribbean populations in London. *Social Science & Medicine.*

Davey Smith, G., Bartley, M. and Blane, D. 1990: The Black report on socioeconomic inequalities in health 10 years on. *British Medical Journal*, 301 (18-25 August), 373-377.

Davison, C., Frankel, S. and Davey Smith, G. 1992: The limits of lifestyle: re-assessing 'fatalism' in the popular culture of illness prevention. *Social Science & Medicine*, 34, 6, 675-685.

Department of Health. 1995: *Independent Enquiry into Inequalities in Health Report. Chairman: Sir Donald Acheson.* London: HMSO.

Donovan, J.L. 1984: Ethnicity and health: a research review. *Social Science and Medicine.* 19, 7, 663-670.

Donovan, J.L. 1986: *We Don't Buy Sickness, It Just Comes.* Aldershot: Gower.

Downey, G. and Moen, P. 1987: Personal efficacy, income and family transitions: a longitudinal study of women heading households. *Journal of Health and Social Behaviour,* 28, 320-333.

Douglas, J. 1992: Black women's health matters: putting women on the research agenda. In H. Roberts (ed) *Women's Health Matters.* London: Routledge, 33-46.

Doyal, L. 1995: *What Makes Women Sick Gender and the Political Economy of Health.* Basingstoke & London: Macmillan Press Limited.

Dressler, W. 1988: Social consistency and psychological distress. *Journal of Health and Social Behaviour,* 29, 79-91.

East London and the City. 1999: *Health in the East End: a public health report 1999/2000. London*: Public Health Directorate, 6-15.

East London and the City. 1998: *Health in the East End: a public health report 1998/1999. London*: Public Health Directorate, 50-55.

Ellis, P. 1986: Introduction - an overview of women in Caribbean society. In P. Ellis (ed) *Women of the Caribbean.* London: Zed Books Limited, 1-24.

England, K.V.L. 1994: Getting personal: reflexivity, positionality and feminist Research. *Professional Geographer,* 46, 1, 80-89.

Eyles, J. and Donovan, J. 1986: *Regional Variations In Perceptions and Experiences of Health and Health Care.* End of award research report to the Social Affairs Committee ESRC (Grant no. G00232140)

Foner, N. 1979: *Jamaica Farewell.* London: Routledge & Kegan Paul.

Fontana, A. and Frey, J.H. 1994: Interviewing: the art of science. In N.K. Denzin and Y.S. Lincoln (eds) *Handbook of Qualitative Research.* London: Sage Publications, 361-376.

Gijsbers van Wijk, C.M.T., Vliet, van K.P.; Kolk, A.M. and Everaerd, W.T.A.M. 1991: Symptom sensitivity and sex differences in physical morbidity: a review of health surveys in the United States and the Netherlands. *Women and Health,* 17, 1, 91-124.

Goss, J. 1996: Introduction to focus groups. *Area,* 28, 2, 113-114.

Goss, J. and Leinbach, T.R. 1996: Focus groups as alternative research practice: experience with transmigrants in Indonesia. *Area,* 28, 2, 115-123.

Goudsmit, E.M. 1994: All in her mind! Stereo-typic views and the psychologisation of women's illnesses. In S. Wilkinson and C. Kitzinger (eds) *Women and Health: Feminist Perspectives.* London: Taylor & Francis Ltd. 7-12.

Guarnaccia, P.J. 1993: *Ataques de nervios* in Puerto Rico: culture-bound syndrome or popular illness? *Medical Anthropology,* 15, 157-170.

Harrison, G. 1993: Psychiatric disorders in ethnic groups: the nature of the evidence. In *North East and North West Thames RHA*, 62-71.

HEA (c.1994): *Depression in Men: Patient information factsheet.* London: The Royal College of Psychiatrists in association with the Royal College of General Practitioners for the Defeat Depression Campaign.

Helman, C. 1990: *Culture, Health and Illness, second edition.* London: Wright.

Herod, A. 1993: Gender issues in the use of inerviewing as a research method. *Professional Geographer,* 45, 3, 305-317.

Heurtin-Roberts, S. 1993: 'High-pertension:' the uses of a chronic folk illness for personal adaption. *Social Science & Medicine,* 37, 3, 285-294.

Hibbard, J. and Pope, C.R. 1993: The quality of social roles as predictors of morbidity and mortality. *Social Science and Medicine,* 36, 3, 217-225.

Holstein, J.A. and Gubrium, J.B. 1997: Active interviewing. In D. Silverman (ed) Qualitative Research: theory, method and practice. London: Sage, 113-129.

hooks, b. 1991: *Yearning: race, gender and cultural politics.* London: Turnaround.

Hunt, L.M., Jordan, B. and Irwin, S. 1989: Views of what's wrong: diagnosis and patients' concepts of illness. *Social Science and Medicine,* 28, 9, 945-956.

Jackson, P. 1993: Changing ourselves: a geography of position. In R.J. Johnston (ed) *The Challenge for Geography: a changing world a changing discipline.* Oxford: Blackwell Publishers, 198-214.

James, W. 1993: Migration, racism and identity formation: the Caribbean experience in Britain. In W. James and C. Harris (eds) *Inside Babylon: the Caribbean diaspora in Britain.* London: Verso, 231-288.

Kandrack, M.A., Grant, K. and Segall, A. 1991: Gender differences in health related behaviour: some unanswered questions. *Social Science and Medicine,* 32, 5, 579-90.

Keheller, D. 1996: A defence of the use of the terms 'ethnicity' and 'culture'. In D. Kelleher and S. Hillier (eds) *Researching Cultural Differences in Health.* London: Routledge, 69-90.

de Koning, K. and Martin, M. 1996: Participatory research in health: setting the context. In K. de Koning and M. Martin (eds) *Participatory Research In Health: issues and experiences.* London: Zed Books Limited, 1-18.

Kitzinger, J. 1996: Introducing focus groups. In N. Mays and C. Pope (eds) *Qualitative Research in Health Care.* London: British Medical Journal Publishing Group, 36-45.

Kooiker, S.E. 1995: Exploring the iceberg of morbidity: a comparison of different survey methods for assessing the occurence of everyday illness. *Social Science and Medicine,* 41, 3, 317-332.

Krieger, N. 1990: Racial and gender discrimination: risk factors for high blood pressure. *Social Science & Medicine*, 30, 12, 1273-1281.

Kvale, S. 1988: The 1000-page question. *Phenomonology & Pedagogy,* 6, 2, 90-106.

Lieban, R.W. 1992: From illness to symbol and symbol to illness. *Social Science & Medicine,* 35, 2, 183-188.

Lillie-Blanton, M. and Laveist, T. 1996: Race/ethnicity, the social environment, and Health. *Social Science & Medicine,* 43, 1, 83-91.

Littlewood, R. 1992: Psychiatric diagnoses and racial bias: empirical and interpretative approaches. *Social Science and Medicine*, 34, 2, 141-149.

Lupton, D. 1994: *Medicine as Culture: illness, disease and the body in Western societies.* London: Sage Publications.

McDowell, L. 1992: Multiple voices: speaking from inside and outside the 'project.' *Antipode,* 24, 1, 56-72.

McDonald, C. 1981: Political-economic structures – approaches to traditional and modern medical systems. *Social Science and Medicine*, 15a, 101-108.

McGovern, D. and Cope, R. 1987: Firsrt psychiatric admission rates of first and second generation Afro-Caribbeans. *Social Psychiatry*, 22, 139-149.

McIlwaine, C. 1995: Gender, race and ethnicity; concepts, realities and policy

Implications. *Third World Planning Review.* 17, 2. 237-243.

MacFarlane, A. 1990: Official statistics and women's health and illness. In H. Roberts (ed) *Women's Health Counts.* London: Routledge. 18-62.

Macintyre, S. 1986: Patterning of health by social positioning in Britain. *Social Science and Medicine,* 23, 4, 393.

Macintyre, S. 1993: Gender differences in the perceptions of common cold symptoms. *Social Science and Medicine,* 36, 1, 15-20.

Macintyre, S., Hunt, K. and Sweeting, H. 1996: Gender differences in health: are things really as simple as they seem? *Social Science & Medicine*, 42, 4, 617-624.

Mama, A. 1993: Woman abuse in London's black communities. In W. James and C. Harris (eds) *Inside Babylon: the Caribbean diaspora in Britain.* London: Verso, 97-134.

May, N. 1997: *Challenging Assumptions: gender issues in urban regeneration.* York: York Publishing Services and Joseph Rowntree Foundation.

Miles, A. 1988: *Women and Mental Illness.* Brighton: Wheatsheaf Books.

Miles, A. 1991: *Women, Health and Medicine.* Milton Keynes: Open University Press.

Miles, M.B. and Huberman, A.H. 1984: Analysis during data collection. In M.B. Miles and A.H. Huberman (eds) *Qualitative Data Analysis: a source book of new methods.* London: Sage Publications, 49-67.

Miles, M.B. and Weitzman, E.A. 1994: Appendix: choosing computer programs for qualitative data analysis. In M.B. Miles and A.H. Huberman (eds) *Qualitative Data Analysis: a source book of new methods.* London: Sage Publications, 311-317.

Miles, R. 1989: *Racism.* London: Routledge & Kegan Paul.

Miller, J. and Glassner, B. 1997: The 'inside' and the 'outside': finding realities in interviews. In D. Silverman (ed) Qualitative Research: theory, method and practice. London: Sage. 99-112.

Modood, T. 1997: *Ethnic Minorities in Britain: diversity and disadvantage.* London, SCPR.

Medical Outcomes Trust. 1994:SF-36 *Health Survey Scoring Manual for English Language Adaptations.* Boston, MA: Medical Outcomes Trust.

Nazroo, J. 1997a: *The Health of Britain's Ethnic Minorities: findings from a*

national survey. London: PSI.

Nazroo, J. 1997b: *Ethnicity and Mental Health: findings from a national community survey.* London: PSI.

Nazroo, J., Edwards, A. and Brown, G. 1997: Gender differences in the onset of depression following a shared life event: a study of couples. *Psychological Medicine,* 27, 9-19.

Nettleton, S. 1997: Governing the risky self: how to become healthy, wealthy and wise. In A. Petersen and R. Bunton (eds) *Foucault: health and medicine.* London: Routledge,207-222.

Oakley, A. 1981 (reprinted 1991): Interviewing women: a contradiction in terms. In H. Roberts (ed) *Doing Feminist Research.* London: Routledge, 30-61.

OPCS 1991 Census. 1993: *County Report: inner and outer London.* London: HMSO.

Oquendo, M.A. 1994: Differential diagnosis of ataques de nervios. *American Journal of Orthopsychiatry,* 65, 1, 60-65.

Petersen, A. 1997: Risk, governance and the new public health. In A. Petersen and R. Bunton (eds) *Foucault: health and medicine.* London: Routledge, 189-206.

Phoenix, A. 1990: Theories of gender and black families. In T. Lovell (ed) B*ritish Feminist Thought: a reader.* Oxford: Basil Blackwell Limited, 119-133.

Pile, S. 1997: Introduction. In S. Pile and M. Kieth (eds) *Geographies of Resistance*. London: routledge, 1-32.

Pill, R. & Stott, N. 1986: Concepts of illness causation and responsibility: some preliminary data from a sample of working-class mothers. In C. Currer and M. Stacey (eds) *Concepts of Health, Ilness and Disease: a comparative perspective*. Oxford: Berg, 259-277.

Popay, J. 1992: 'My health is all right, but I'm just tired all the time' women's experience of ill health. In H. Roberts (ed) *Women's Health Matters.* London: Routledge, 99-120.

Popay, J., Bartley, M. and Owen, C. 1993: Gender inequalities in health: social position, affective disorders & minor physical morbidity. *Social Science & Medicine,* 36, 1, 21-32.

Pope, C. and Mays, N. 1993: Opening the black box: an encounter on the corridors of health services research. *British Medical Journal,* 306 (30th Jan). 315-318.

Potter, J. and Wetherell, M. 1987: *Discourse and Social Psychology*. London: Sage Publications, 165-176.

Pulsipher, L.M. 1993: 'He won't let she stretch she foot' gender relations in traditional West Indian houseyards. In C. Katz and J. Monk (eds) *Full Circles: geographies of women over the life course.* London: Routledge, 107-21.

Rosenfield, S. 1989: The effects of women's employment: personal control and sex differences in mental health. *Journal of Health and Social Behaviour,* 30 (March), 77-91.

Rudat, K. 1994: *Black and Minority Ethnic Groups In England.* MORI Reseach Unit: Health Education Authority.

Saltonstall, R. 1993: Healthy bodies, social bodies: men's and women's concepts and practices of health in everyday life. *Social Science & Medicine*, 36, 1, 7-14.

Shaukat, N. and Cruikshank, J. 1993: Coronary artery disease: impact upon black and ethnic minority people. In A. Hopkins and V. Bahl (eds) *Access to Health Care for People from Black and Ethnic Minorities*, London: Royal College of Physicians, 133-146.

Sheldon, T.A. and Parker, H. 1992a: Race and ethnicity in health research. *Journal of Public Health Medicine,* 14, 2, 104-110.

Sheldon, T.A. and Parker, H. 1992b: The use of 'ethnicity' and 'race' in health research: a cautionary note. In W.I.U. Ahmad (ed) *The Politics of 'Race' and Health.* Race Relations Research Unit: University of Bradford, 55-71.

Shouls, S., Congdon, P. and Curtis, S. 1996: Modelling inequality in reported long term illness in the UK: combining individual and area characteristics. *Journal of Epidemiology and Community Health*, 50, 366-376.

Simon, R. 1997: The meanings individuals attach to role identities and their implications for mental health. *Journal of Health and Social Behaviour*, 38 (Sept), 256-274.

Smaje, C. 1995a: *Context and culture in the health of ethnic groups.* Draft paper to ESRC seminar series.

Smaje, C. 1995b: *Health, 'Race', and Ethnicity: making sense of the evidence.*

London: King's Fund Institute.

Smith, S. 1991: Processes of social categorisation. In C. Philo (ed) *New Words. New Worlds: reconceptualising social and cultural geography.* Aberystwyth: Cambrian Printers, 28-30.

Solomos, J. 1993: *Race and Racism in Britain, second edition.* London: MacMillan Press Ltd.

Solomos, J. and Back, L. 1996: *Racism and Society.* London: MacMillan Press Ltd.

Stainton-Rogers, W. 1991: *Explaining Health and Illness: an exploration of diversity.* London: Harvester Wheatsheaf.

Stubbs, P. 1993: 'Ethnically sensitive' or 'anti-racist'? Models for health research and service delivery. In W.I.U. Ahmad (ed) *The Politics of 'Race' and Health.* Race Relations Research Unit: University of Bradford, 34-47.

Sutcliffe, D. and Tomlin, C. 1986: The black churches. In D. Sutcliffe and A. Wong (eds) *The Language of the Black Experience.* Oxford: Basil Blackwell Ltd, 15-31.

Thoits, P. 1991: On merging identity theory and stress research. *Social Psychology Quarterly, 54,* 101-112.

Thomas, C. 1999: Understanding health inequalities: the place of agency. *ESRC Newsletter: Health Variations,* 3, 10-11.

Thorogood, N. 1990: Caribbean home remedies and their importance for black women's health care in Britain. In P. Abbott and G. Payne (eds) *New Directions in the Sociology of Health.* London: The Falmer Press, 140-152.

Townsend, P. and Davidson, N. 1982: *Inequalities in Health: the Black report.* Harmondsworth: Penguin.

Townsend, P., Davidson, N. and Whitehead, M. 1992: *Inequalities in health: the black report and the health divide.* London: Penguin.

Verbrugge, L. 1985: Gender and health: an update on hypotheses and evidence. *Journal of Health and Social Behaviour,* 26 (September), 156-182.

Walters, V. 1992: Stress, anxiety and depression: women's accounts of their health Problems. *Social Science & Medicine,* 36, 4. 393-402.

Watson, J. 1993: Male body image and health beliefs: a qualitative study and implications for health promotion practice. *Health Education Journal,* 52, 4. 246-252.

Williams, R. 1993: Religion and illness. In A. Radley (ed) *Worlds of Illness: biographical and cultural perspectives of health and disease*. London: Routledge, 71-91.

Wong, A. 1986: Creole as a language of power and solidarity. In D. Sutcliffe and A. Wong (eds) *The Language of the Black Experience*. Oxford: Basil Blackwell Ltd, 109-122.

EXTENDED BIBLIOGRAPHY.

Andresen, E.M. *et al.* 1995: Comparing the performance of health status measures for healthy older adults. *Journal of American Geriatrics Society,* 43, 9, 1030-40.

Annandale, E. and Hunt, K. 1990: Masculinity, femininity and sex: an exploration of their relative contribution to explaining gender differences in health. *Sociology of Health and Illness,* 12, 1, 24-46.

Antrobus, P. 1986: Employment of women workers in the Caribbean. In P. Ellis (ed)*Women of the Caribbean.* London: Zed Books Limited, 33-34.

Arber, S. and Ginn 1993: Gender and inequalities in health in later life. *Social Science and Medicine,* 36, 1, 33-46.

Armstrong, D. 1994: Bodies of knowledge/knowledge of bodies. In C. Jones and R. Porter (eds) *Reassessing Foucault: power,medicine and the body.* London: Routledge, 17-27.

Back, L. 1993: Masculinity and fieldwork in a South-London adolescent community. In D. Bell, P. Caplan, and W.J. Karim (eds) *Gendered Fields: women,men and ethnography.* London: Routledge, 215-233.

Back, L. 1996: *New Ethnicities and Urban Culture: racisms and multiculture in young lives.* London: UCL Press.

Baruch, G.K. and Barnett, R. 1986: Role quality, multiple role involvement and psychological well-being in midlife women. *Journal of Personality and Social Psychology,* 51, 578-585.

Bertrand, J., Brown, J. and Ward, V. 1992: Techniques for analyzing focus group Data. *Evaluation Review,* 16, 2, 198-209.

Blaxter, M. 1985: Self-definition of health status and consulting rates in primary care. *Quarterly Journal of Social Affairs,* 1, 131-171.

Bordo, S. 1992: Postmodern subjects, postmodern bodies. *Feminist Studies,* 18, 1, 159-175.

Bowling, A. 1991: *Measuring Health: a review of quality of life measurement scales.* Milton Keynes: Open University Press.

Bowling, A. 1994: *Measuring Disease: a review of disease specific quality of*

life measurement scales.

Brazier, J.E. *et al.* 1996: Using the SF-36 and Euroqol on an elderly population. *Quality of Life Research,* 5, 195-204.

Buck, N. 1990: The British Household Panel Study. *ESRC Data Archive Bulletin 46,* 4-6.

Buck, N., Gerschuny, J., Rose, D. and Scott, J. (eds) 1994: *Changing Households: the British household Panel Survey 1990-2.* Colchester: ESRC Research Centre on micro-Social Change.

Buijs, G. 1993: Introduction. In G. Buijs (ed) *Migrant Women: crossing boundaries and changing identities.* Oxford: Berg Publishers Limited, 1-19.

Cinnirella, M. and Lowenthal, K. 1996: *Religious influences on beliefs about mental illness in minority groups.* Paper presented at Religious Issues in Mental Health Among Minority Groups: Issues in Britain in the 1990s (symposium).

Cook, J.A. and Fonow, M.M. 1986: Knowledge and women's interests: issues of epistemology and methodology in feminist sociological research. *Sociological Enquiry,* 56, 2, 2-29.

Drake, J. 1997: Review essay: third wave feminisms. *Feminist Studies,* 21, 1, 97-108.

Duncombe, J. and Marsden, D. 1995: 'Workaholics' and 'whingeing women': theorising intimacy and emotion work - the last frontier of gender inequality? *The Sociological Review,* 43, 1, 150-169.

Elliott, S.J. 1995: Psychosocial stress, women and heart health: a critical review. *Social Science and Medicine,* 40, 1, 105-15.

Evers, H. 1985: The frail elderly woman: emergent questions in ageing and women's health. In E. Lewin and V. Olesen (eds) *Women, Health and Healing Toward a New Perspective.* London: Tavistock Publications, 86-112.

Fanon, F. 1952: *Black Skin, White Masks* (translated 1986). London: Pluto Press.

Feldman, M.S. 1995: *Strategies for Interpreting Qualitative Data.* London: Sage.

Finch, J. 1986: Introduction. *Research and Policy.* London: Falmer, 4-10.

Forrester, D.A. 1986: Myths of masculinity: impact upon men's health. *Nursing Clinics of North America,* 21, 1, 15-23.

Fox, T. 1994: Race and gender in collaborative learning. In S. Barr Reagan, T. Fox and D. Bleich (eds) *Writing With: new directions in collaborative teaching,learning and researching.* 11-121.

Gabbard-Alley, A.S. 1995: Health communication and gender: a review and Critique. *Health Communication,* 7, 1, 35-54.

Game, A. and Pringle, R. 1983: Sex and power in hospitals: the division of labour in the 'health' industry. In A. Game and R. Pringle (eds) *Gender At Work.* London: George Allen & Unwin, 94-118.

Gepkens, A. and Gunning-Schepers, L.J. 1996: Interventions to reduce socio-economic health differences: a review of the international literature. *European Journal of Public Health,* 6, 218-226.

Gibson-Graham, J.K. 1994: 'Stuffed if I know!: reflections on post-modern feminist research. *Gender, Place and Culture,* 1, 2, 205-224.

Gijsbers Van Wijk, C.M.T., Kolk, A.M., Van Den Bosch, W.J.H.M. and Van Den Hoogen, H.J.M. 1992: Male and female morbidity in general practice: the nature of sex differences. *Social Science and Medicine,* 35, 5, 665-675.

Gregson, N. and Lowe, M. 1995: 'Home'-making: on the spatiality of daily social reproduction in contemporary middle-class Britain. *Transactions, Institute of British Geographers, NS* 20, 2 224-235.

Hayes, V., Morris, J., Wolfe, C. and Morgan, M. 1995: The SF-36 health survey questionnaire: is it suitable for use with older adults? *Age and Ageing,* 24, 2, 120-125.

Henry, F. and Wilson, P. 1975: The status of women in Caribbean societies: an overview of their social, economic and sexual roles. *Social and Economic Studies,*24, 165-198.

Hill, W.M.F. 1977: *Learning Thru Discussion: guide for leaders and members of discussion groups.* London: Sage Publications Limited.

Hinchcliffe, S.J. *et al.* 1997: Software for qualitative research: 2. Some thoughts on 'aiding.' *Environment and Planning A,* 29, 1109-1124.

Holbrook, B. and Jackson, P. 1996: Shopping around: focus group research in North London. *Area,* 28, 2, 136-142.

House, J.S. *et al.* 1986: Occupational stress and health among men and women in the Tecumseh Community Health Study. *Journal of Health and Social Behaviour,* 27, 62-77.

Howlett, B., Waqar, I. and Murray, R. 1992: An exploration of white, Asian and Afro-Caribbean peoples' concepts of health and illness causation. *New Community,* 18, 2, 281-292.

Hunt, S.M. and McKenna, S.P. 1993: Measuring patients` views of their health. SF-36 misses the mark. *British Medical Journal (letter),* 307 (10th July), 125.

Independent Review Panel to ELCHA & Newham Council 1995: *The Woodley Team Report.* London: East London & the City Health Authority and Newham Council.

Hunter, A.G. and Davis, J.E. 1994: Hidden voices of black men: the meaning, structure, and complexitiy of manhood. *Journal of Black Studies*, 25, 1, 20-40.

Jemmott III, J. B. and Locke, S. E. 1984: Psychosocial factors, immunologic mediation, and human susceptibility to infectious diseases: how much do we know? *Psychological Bulletin,* 95, 1, 78-108.

Jenkinson, Wright and Coulter 19? The SF-36 health survey questionnaire: a valid measure if used within it's limits. *British Medical Journal (letter*), 307 (14th Aug), 449.

Johnson, P.A. *et al.* 1995: Comparison of the Medical Outcomes Study Short-Form 36-Item Health Survey in black patients and white patients with acute chest pain. *Medical Care,* 33, 2, 145-160.

Johnson, A. and Johnson, O.R. 1990: Quality into quantity: on the measurement potential of ethnographic fieldnotes. In R. Sanjek (ed) *Fieldnotes: the making of anthropology.* London: Cornell University Press, 161-186.

Jones, K. and Moon, G. 1987: *Health, Disease and Society: an introduction to medical geography.* London: Routledge.

Joyce, C.R.B. 1995: Use, misuse and abuse of questionnaires on quality of life. *Patient Education and Counselling,* 26, 319-323.

Kandel, D.B., Davies, M. and Raveis, V.H. 1985: The stressfulness of daily social roles for women: marital, occupational and household roles. *Journal of Health and Social Behaviour,* 26, 64-78.

Karlson, E. *et al.* 1997: The relationship of socio-economic status, race and modifiable risk factors to outcomes in patients with systemic lupus erythematosus. *Arthritis and Rheumatism,* 40, 1, 47-56.

Katz, C. and Monk, J. 1993: Making connections: space, place and the lifecourse. In C. Katz and J. Monk (eds) *Full Circles: geographies of women*

over the lifecourse. London: Routledge. 264-278.

Kearns, R. 1993: Place and health: towards a reformed medical geography. *Professional Geographer,* 45, 2, 139-147.

Krueger, R.A. 1994*: Focus Groups: a practical guide for applied research, second edition.* London: Sage Publications.

Krug, G. and Hepworth, J. 1997: Poststructuralism, qualitiative methodology and public health: research methods as a legitimation strategy for knowledge. *Critical Public Health,* 7, 1 & 2, 50-60.

Lane, S.D. and Meleis, A.I. 1991: Roles, work, health perceptions and health resources of women (Egypt). *Social Science and Medicine,* 33, 10, 1197.

LaVeist, T.A. 1993: Segregation, poverty and empowerment: health consequences for African Americans. *The Milbank Quarterly,* 71, 1, 41-64.

Lawrence, E. 1982: In the abundance of water only the fool is thirsty: sociology and black 'pathology.' In Centre for Contemporary cultural Studies *The Empire Strikes Back: race and racism in 70s Britain.* London: Hutchinson, 100-135.

Leaf, P.J. and Bruce, M.L. 1987: Gender differences in the use of mental health-related services: a re-examination. *Journal of Health and Social Behaviour,* 28, 171-183.

Lloyd, B. 1995: *Masculine Identity: Challenges in Childhood.* Notes from a talk given at 'The Health of the Nation's Men' conference July 11th.

Lloyd, T. 1996: *Men's Health Review* commissioned by Men's Health Forum, sponsored by Merck Sharp & Dohme Ltd.

Longhurst, R. 1996: Refocusing groups: pregnant women's geographical experiences of Hamilton, New Zealand/Aotearoa. *Area,* 28, 2, 143-149.

Loring, M. and Powell, B. 1988: Gender, race and DSM-III: a study of the objectivity of psychiatric diagnostic behaviour. *Journal of Health and Social Behaviour* Vol 29, 1-22.

Lynam, J. 1985: Support networks developed by immigrant women. *Social Science and Medicine,* 21, 3, 327-333.

Lyons, R.A., Fielder, H. and Littlepage, B.N.C. 1995: Measuring health status with the SF-36: the need for regional norms. *Journal of Pulic Health Medicine,* 17, 1, 46-50.

Lyons, R.A., Perry, H.M. and Littlepage, B.N.C. 1994: Evidence for the validity

of the Short form 36 Questionnaire (SF-36) in an elderly population. *Age and Ageing,* 23, 3, 182-184.

McAllister, G. and Farquhar, M. 1992: Health beliefs: a cultural division? *Journal of Advanced Nursing,* 17, 1447-1454.

McCalman, J.A. 1990: *The Forgotten People: carers in three minority ethnic communities in Southwark.* London: King's Fund.

McHorney, C.A., Kosinski, M. and Ware, J.E. Jr 1994: Comparisons of the costs and quality of norms for the SF-36 health survey collected by mail versus telephone interview: results from a national survey. *Medical Care*, 32, 6, 551-567.

McHorney, C.A. *et al.* 1994: The MOS 36-item short-form health survey (SF-36): III. Tests of data quality, scaling assumptions and reliability across diverse patient groups. *Medical Care,* 32, 1, 40-66.

Martin, M. 1996: Issues of power in the participatory research process. In K. de Koning and M. Martin (eds) *Participatory Research In Health: issues and experiences.* London: Zed Books Limited, 82-93.

Mays, N. and Pope, C. 1995: Rigour and qualitative research. *British Medical Journal,* 311 (8 July), 109-112.

Mercer, K. and Julien, I. 1988/96: Race, sexual politics and black masculinity: a dossier. In R. Chapman and J. Rutherford (eds) *Male Order: unwrapping masculinity.* London: Laurence & Wishart, 97-164.

NAHAT 1996: *Health Care for Black & Minority Ethnic People.* Birmingham: NAHAT.

Nodie, O.S. and Smulyan, L. 1989: *Collaborative Action Research: a developmental approach.* Lewes: The Falmer Press.

NFER (National Foundation for Educational Research) 1995: *Health and Well-Being In the 1990's: a study of young people's attitudes and behaviour in the London borough of Newham.* Slough: NFER.

NHS Executive 1996: The criteria for assessing proposals. *Commissioning Document for Applicants, North Thames Inner City Health R & D (programme issue 100: briefing)*, 10-18.

OPCS 1996: *Living in Britain: results from the 1994 General Household Survey.* London: HMSO.

Pharoah, C. 1995: *Primary Health Care for Elderly People from Black and*

Minority Ethnic Communities. London: Studies in Ageing, Age Concern Institute of Gerontology, King's College.

Pile, S. 1993: Human agency and human geography revisited: a critique of 'new models' of the self. *Transactions of the Institute of British Geographers NS,* 18, 122-139.

Rabinow, P. (ed) 1984: *The Foucault Reader.* London: Penguin Books.

Ren, X.S. and Amick, B.C. 1996: Racial and ethnic disparities in self-assessed health status: evidence from the National Survey of Families and Households. *Ethnicity & Health,* 1, 3, 293-303.

Reuben, D.B. *et al* 1995: Measuring physical function in community-dwelling older persons: a comparison of self-administered, interview administered and performance-based measures. *Journal of American Geriatrics Society,* 43, 1, 17-23.

Richards, L. and Richards, T. 1994: From filing cabinet to computer. In A. Bryan and R.G. Burgess (eds) *Analysing Qualitative Data.* London: Routledge, 146-72.

Richters, A. 1992: Introduction. *Social Science & Medicine,*35, 6, 747-751.

Ruta, D. *et al.* 199?: The SF-36 health survey questionnaire: a valid measure of health status. *British Medical Journal (letter),* 307, (14th Aug), 448.

Sanjek, R. 1990: On ethnographic validity. In R. Sanjek (ed) *Fieldnotes: the making of anthroplogy.* London: Cornell University Press, 385-418.

Savitz, D.A. 1994: In defense of black box epidemiology. *Epidemiology,* 5, 5, 550-552.

Seeman, M. and Seeman, T.E. 1983: Health behaviour and personal autonomy: a longitudinal study of the sense of control in illness. *Journal of Health and Social Behaviour,* 24 (June), 144-160.

Segall, A. 1987: Age differences in lay conceptions of health and self care responses to illness. *Canadian Journal on Ageing,* 6, 1, 47-65.

Sheldon, T. 1993: Measuring patients' views of their health. Reliability of SF-36 remains uncertain. *British Medical Journal (letter),* 307 (10th July), 125-6.

Shorey-Bryan, N. 1986: The making of male-female relationships in the Caribbean. In P. Ellis (ed) *Women of the Caribbean.* London: Zed Books Limited, 69-73.

Silverman, D. 1993 (reprinted 1994): *Interpreting Qualitative Data: methods*

for analysing talk, text and interaction. London: Sage, 90-114.

Skelton, R. 1988: Man's role in society and it's effect on health. *Nursing, 2, 6,* 953-956.

Staples, R. 1985: Changes in black family structure: the conflict between family ideology and structural conditions. *Journal of Marriage and the Family,* 47 (November), 1005-1013.

Steedman, C. 1986 (reprinted 1991): *Landscape for a Good Woman, a Story of Two Lives.* London: Virago Press Limited.

Turner, J. and Noh, S. 1983: Class and psychological vulnerability among women: the significance of social support and personal control. *Journal of Health and Social Behaviour*, 24, 2-15.

Victor, R.S. 1986: Family relations and support systems. In P. Ellis (ed) *Women of the Caribbean.* London: Zed Books Limited, 84-87.

Wade, P. 1993: Sexuality and masculinity in fieldwork among Columbian blacks. In D. Bell, P. Caplan and W.J. Karina (eds) *Gendered Fields: women, men and ethnography.* London: Routledge, 199-214.

Ware, J.E. Jr *et al.* 1995: Evaluating translations of health status questionnaires: methods from the IQOLA project. *International Journal of Technology Assessment in Health Care*, 11, 3, 525-551.

Weinberger, M. *et al.* 1994: Assessing health-related quality of life in elderly outpatients: telephone versus face-to-face administration *Journal of American Geriatrics Society,* 42, 12, 1295-1299.

Westwood, S. 1990: Racism, black masculinity and the politics of space. In J. Hearn and D. Morgan (eds) *Men, Masculinity and Social Theory.* London: Unwin Hyman, 55-71.

Widgery, D. 1991: *Some Lives! A GP's East End.* London: Sinclair-Stenvenson Ltd.

Williams, C.I. 1986: The role of women in Caribbean culture. In P. Ellis (ed) *Women of the Caribbean.* London: Zed Books Limited, 109-114.

Wolcott, H.F. 1990: *Writing Up Qualitative Research.* London: Sage Publications Ltd.

Wolinsky, F.D. and Stump, T.E. 1996: A measurement model of the Medical Outcomes Study 36-item short-form health survey in a clinical sample of disadvantaged, older, black, and white men and women. *Medical Care*, 34, 6,

537-548.

Zeigler, D.J., Brunn, S.D. and Johnson Jr, J.H. 1994: Focus group research: an emerging field in social geography. *Abstract from 90th Annual Meeting of the Association of American Geographers.*

Zeigler, D.J., Brunn, S.D. and Johnson Jr, J.H. 1996: Focusing on Hurricane Andrew through the eyes of the victims. *Area,* 28, 2. 124-129.

Questions For Discussion.

The questions you have been asked to fill in have been taken from the following surveys: the Short Form 36 Question Health Survey (SF-36); the Black and Minority Ethnic Groups Health and Lifestyles Survey, 1992; and the British Population Census, 1991.

To answer the questions you are asked to circle your response to a number of statements given for each question. Please fill in these questions to the best of your ability.

If you have any difficulty answering or understanding the instructions please do not hesitate to ask for help or advice.

1. In general, would you say your health is:

(Circle one)

Excellent 1
Very good. 2
Good. 3
Fair. 4
Poor 5

2. Compared to one year ago, how would you rate your health in general now?

(Circle one)

Much better now than one year ago 1
Somewhat better now than one year ago. 2
About the same as one year ago 3
Somewhat worse now than one year ago 4
Much worse than one year ago 5

3. Do you have any long term illness, health problem or handicap which limits your daily activities or the work that you can do? (This includes problems that are due to old age.)

(Circle one)

Yes, I have a health problem which limits my activities 1
No, I have no such health problems 2

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	(Circle one number on each line)	
	YES	**NO**
a. Cut down the **amount of time** you spend on work or other activities	1	2
b. **Accomplished less** than you would like	1	2
c. Didn't do work or other activities as **carefully** as usual	1	2

5. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups?

(Circle one)

Not at all 1
Slightly 2
Moderately 3
Quite a bit 4
Extremely 5

6. How much bodily pain have you had during the past 4 weeks?

(Circle one)

None. 1
Very mild 2
Mild. 3
Moderate 4
Severe 5
Very severe. 6

7. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

(Circle one)

Not at all. 1
A little bit. 2
Moderately. 3
Quite a bit. 4
Extremely 5

8. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks -

	(Circle one number on each line)					
	All of the time	**Most of the time**	**A good bit of the time**	**Some of the time**	**A little of the time**	**None of the time**
Did you feel full of life?	1	2	3	4	5	6
Have you been a nervous person?	1	2	3	4	5	6
Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
Have you felt calm and peaceful?	1	2	3	4	5	6
Did you have a lot of energy?	1	2	3	4	5	6
Have you felt downhearted and low?	1	2	3	4	5	6
Did you feel worn out?	1	2	3	4	5	6
Have you been a happy person?	1	2	3	4	5	6
Did you feel tired?	1	2	3	4	5	6

9. How TRUE or FALSE is each of the following statements for you?

	(Circle one number on each line)				
	Definately True	**Mostly True**	**Don't Know**	**Mostly False**	**Definately False**
a. I seem to get ill more easily than other people	1	2	3	4	5
b. I am as healthy as anybody I know	1	2	3	4	5
c. I expect my health to get worse	1	2	3	4	5
d. My health is excellent	1	2	3	4	5

11. Which, if any, of the things on the list below do you usually do to cope with worry?

	(Circle one number on each line)	
a. Try not to think about it	**YES**	**NO**
b. Discuss it with a close friend	1	2
c. Discuss it with a relative	1	2
d. Work harder to occupy myself	1	2
e. Take more exercise/more physical activity	1	2
f. Go to pub/have a drink	1	2
g. Smoke more	1	2
h. Drink more	1	2
i. Eat more	1	2
j. Pray/meditate	1	2
k. Get help and advice from a doctor	1	2
l. Get prescription from doctor	1	2
m. Get help and advice from counsellor or advice organisation	1	2
n. Spend more time thinking about my problems	1	2
o. Spend more time going out with my friends or relatives	1	2
p. Never have any worry	1	2
q. None of these	1	2
r. Don't know	1	2

12. Apart from the people you live with, do you have any other relatives whom you speak to or see <u>regularly</u>?

(circle one)

Yes, I see/speak to a relative regularly 1
No, I don't see/speak to a relative regularly 2

13. Do you have any friends whom you speak to or see <u>regularly</u>?

(circle one)

Yes, I see/speak to a friend regularly 1
No, I don't see/speak to a friend regularly 2

14. From the list below indicate which, if any of these, you have done in the <u>past fortnight</u>?		
	(Circle one number on each line)	
	YES	**NO**
a. Went to visit relatives	1	2
b. Had relatives visit me	1	2
c. Went out with relatives	1	2
d. Spoke to relatives on the phone	1	2
e. Went to visit friends	1	2
f. Had friends visit me	1	2
g. Went out with friends	1	2
h. Spoke to friends on the phone	1	2
i. Spoke to neighbours	1	2
j. Spoke to health professional (e.g. doctor, nurse, midwife, health visitor)	1	2
k. Attended an adult education or night school class	1	2
l. Participated in a voluntary group or local community group	1	2
m. Participated in community or religious activities	1	2
n. Went to a leisure centre	1	2
o. Went to another social outing (write in the space provided)	1	2
p. None of these	1	2

15. If you needed help and advice which, if any, of the people in the list below could you discuss personal issues with?		
	(Circle one number on each line)	
	YES	**NO**
a. Partner or spouse	1	2
b. Female relatives	1	2
c. Male relatives	1	2
d. Female friends	1	2
e. Male friends	1	2
f. Girlfriend	1	2
g. Boyfriend	1	2
h. Neighbours	1	2
i. Community worker	1	2
j. Community leader	1	2
k. Social worker	1	2
l. Counsellor/therapist	1	2
m. Priest or clergy or religious leader	1	2
n. Home help	1	2
o. Meals-on-wheels	1	2
p. Family doctor/GP	1	2
q. Nurse	1	2
r. Midwife	1	2
s. Health visitor	1	2
t. Someone else (please write in the space provided)	1	2
u. None of these	1	2

APPENDIX II. Group Interview 'Aide Memoire'

Discussion of Questionnaire.

- *Questions 1-3: defining and measuring health*
- *Questions 4-7: emotional problems, body pain, effects on activities*
- *Questions 8-9: influences of perception of personal health using checklists*
- *Questions: 10-11: 'worrying' events and coping with 'worries'*
- *Questions 12-15: social support – who does it include and how important is it*

Prompts for questions 1-3:

Did you find it easy to define 'health'?

What understanding of 'health' have you used to answer the questions?

Did you separate physical/mental/emotional health, when you answered?

Can definitions of 'health' (incl. Physical and mental health) vary across age/ gender/culture, do you think?

Prompts for questions 4-7:

Is it easy to recall 4 weeks of emotions and bodily pain?

What does the phrase 'emotional problems' mean to you?

Do you separate emotions from body pain?

Do you find it's more acceptable to let either emotions or pain interfere with your activities?

Prompts for questions 8-9:

How much are the answers you give influenced by who will read them?

e.g. male friend/relative, female friend relative, partner, doctor, others?

Do you think labels like 'down in the dumps' carry a stigma?

Prompts for questions 10-11:

What does 'worrying' mean? Is it an appropriate term to use? Alternatives?

Is 'worrying' important when considering how healthy you are?

How easy is it to admit how 'worrying' you find events?

Anything to add to list? Different 'worries'/different ways of coping?

Prompts for questions 12-15:

Are these questions important when considering how healthy you are?

Are there different social supports for you?

APPENDIX III. In-depth Interview 'Aide Memoire'

Guidelines for In-depth Interviews.

Starting off: have you experienced any physical or emotional ill health recently?

Focus on 'minor' illnesses where possible

If you have 'minor' illnesses what are the symptoms?

Do you treat these 'minor' symptoms as illness or as something else?

Can these illnesses trigger other health problems?

How do you feel when you experience ill health?

Understandings of what causes ill health.

Do you think these illnesses were brought on by something?

Any particular event?

Any particular mood/emotion/frame of mind?

Is it down to something much broader/less definite?

A personal disposition (e.g. anxious/nervous person)? Is this lifelong?

Social congruity: connections between health and social position.

Considering gender/age/'race' do you feel there are expectations of you in life?

Do you notice whether expectations of you are different in the Caribbean and Britain?

If so, is it hard to know what to do sometimes?

Are there different expectations from your own generation compared to other age groups?

Are there expectations of you as a black woman/man in Britain?

Do expectations, if any, cause you any problems? E.g. sexism, racism, etc?

If so, could this affect your health in any way?

Do you try to overcome any problems that you experience? How?

Strategies of coping.

When you are not well, do you do anything to make yourself feel better?

Describe behaviour, and reasons why thought to be appropriate.

Do you involve other people to make you feel better?

Who (dr, friends, family, preacher, etc)? Why these?

How important is prayer and faith in God to healing process?

Caribbean identity.

Do you think you use Caribbean ways to deal with ill health?

Explain answer.

What are Caribbean ways?

Extra questions to consider:

Do you think that women are 'allowed'/not 'allowed' to be ill more than men are in this society?

Does illness have a stigma to it? Do you feel a stigma about any illness?

Do cultural lifestyle and ways of being bring about feelings of belonging?

Would you feel an outsider/more lost without the Caribbean culture?

Do you think a sense of belonging might be important for your health?

APPENDIX IV List of Notations

Transcript notations.

One or more colons indicate an extension of the proceeding vowel sound:

A: Yea::h, I see::

Underlined words indicate where words are uttered with added emphasis; capitals indicate words uttered louder than the surrounding talk:

A: It's not right, not AT ALL

A full stop before a word or sound indicates an audible intake of breath:

A: I think I .hh I need more

Round brackets indicate that material in the brackets is either inaudible or there is doubt about it's accuracy:

A: I (couldn't tell you) that

Material in square brackets is clarificatory information. Empty square brackets indicate that some transcript has been deliberately omitted:

A: Brian [the speaker's brother] said [] it's okay

An equal sign at the end of a speaker's utterance and at the start of the next utterance indicates the absence of a discernable gap:

A: Anyway=

B: = Okay, okay

(notations above are taken from Jefferson, cited in Potter & Wetherall, 1987: 188-189)

Empty round brackets indicate that words and sounds are inaudible.

Bold and italic emphasis together indicates a particular group noise of length (for group interviews).